

## 2006 Employee Benefits Developments — A Look Back

As in most recent years, the key employee benefits issues in 2006 were related to health benefits. Efforts to control healthcare costs — consumer-driven health plans and wellness programs, in particular — were a big part of employee benefits developments in 2006. To help put the year's developments into perspective, we offer a look back at some benefits highlights from 2006.

### *Consumer-Driven Health Care*

- Congress Passes Legislation That Enhances HSAs
- Comparable Contributions to HSAs: IRS Issues Final Regulations
- DOL Issues Further Guidance on Which HSAs Are Subject to ERISA

### *Wellness Programs*

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- The ADA: Impact on Wellness Programs
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- Medicare Part D: Annual Requirements for Plan Sponsors
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- State 'Fair Share' Legislative Attempts
- Pension Protection Act of 2006
- Debit Cards and Flex Spending Accounts: New IRS Guidance
- IRS Issues Proposed Regulations on Expenses Reimbursable by DCAPs
- Final USERRA Regulations Address Benefits Issues

If you find that you would like more information about any of these issues, please contact your local Willis office to schedule a meeting.

### *Consumer-Driven Health Care*

#### **Congress Passes Legislation Enhancing HSAs**

The year's biggest development in consumer-driven health care came as the 109th Congress drew to a close. Congress enacted legislation that included several positive changes, including those described below, to the rules governing Health Savings Accounts (HSAs).

- HSA contributions are no longer limited to the

annual deductible. In 2007, an individual's annual limit for tax-favored HSA contributions is \$2,850 if the individual has single high-deductible health plan (HDHP) coverage and \$5,650 if the individual has family HDHP coverage. Previously, the contributions could not have exceeded the HDHP deductible.

- Full-year contributions are now allowed for individuals who are ineligible for HSA contributions for part of a year. An individual can now have a full year's worth of tax-favored contributions to an HSA

even if the individual was not eligible for those contributions throughout the year. An individual who uses this provision must meet several conditions in the following year, however, in order to avoid taxable income and excise taxes.

- “Qualified HSA distributions” may be made from health flexible spending accounts (health FSAs) or health reimbursement arrangements (HRAs) to HSAs. Employers have the option to amend their health FSAs or HRAs so that such plans can make a one-time “qualified HSA distribution.” Such transfers are subject to several limitations, including one that prevents any transfer exceeding the FSA or HRA balance as of September 21, 2006.
- HSA contributions may be made during health FSA grace period. If an individual’s health FSA balance is zero before the 2 ½ month grace period begins, the individual is eligible to make an HSA contribution. Under the new legislation, a person who has a balance during the grace period is also eligible to make tax-favored HSA contributions if the individual makes a qualified HSA distribution that meets certain conditions.
- Comparability rules now permit employers to make higher contributions for non-highly compensated employees’ HSAs than for other employees’ HSAs and still comply with the rules requiring comparable contributions to all employees HSAs.
- The IRS will now be required to release applicable cost of living adjustments to HSA limits by June 1.

The HSA changes should make HSAs more flexible and, in most cases, will allow eligible individuals to set aside larger amounts than permitted in previous years. Therefore, the changes are likely to make HSAs more attractive to both employers and employees. (Please refer to *Willis Employee Benefits Alert #91, Health Savings Account Legislation Makes HSAs More Flexible* for detailed information about this legislation.)

#### *Consumer-Driven Health Care*

### **Comparable Contributions to HSAs: IRS Issues Final Regulations**

Summer 2006 brought us a major consumer-driven health care development — final IRS regulations interpreting the comparable contributions requirements that apply to HSAs. Employer contributions that are not made through a Section 125 plan must be “comparable” for all comparable participating employees. (Very generally, that means that an employer must contribute an equal dollar amount or an equal percentage of the HDHP deductible to the HSA of each employee who is eligible, note however, the new exception discussed above.) Failure to make comparable contributions can result in a steep excise tax equal to 35% of the contributions.

There is an exception to the comparability rules that makes them inapplicable to employer contributions made through a cafeteria plan. The new regulations clarify which employer contributions are deemed to be made through a cafeteria plan. The rules also clarify that only contributions to employees’ HSAs are subject to the comparability rules, and they define who is and is not an employee for comparability purposes. (Please refer to *Willis Employee Benefits Alert #76, Comparable Contributions to HSAs: IRS Issues Final Regulations* for additional information.)

#### *Consumer-Driven Health Care*

### **DOL Issues Further Guidance on Which HSAs Are Subject to ERISA**

In 2004, the DOL published guidance that stated a general “voluntary establishment” rule for HSAs. Under that rule, employer contributions to an HSA will not convert the HSA into an ERISA plan as long as the establishment of the HSA is completely voluntary for the employee. (For more information on the 2004 DOL guidance, see *Willis Employee Benefits Alert #25 (Part 1), HSAs – Now That We Have All the Guidance, What Do We Have?*)

In 2006, the DOL issued guidance explaining that its 2004 “voluntary establishment” rule does not require an employer to avoid “endorsing” HSAs. (Examples of endorsement include assisting employees with paperwork and selecting the features of a program.) Under the “voluntary establishment” rule, only the employees’ establishment of the HSA need be completely voluntary. The 2006 guidance further explained that, under the “voluntary establishment” rule, an employer will not convert an HSA into an ERISA plan even if it unilaterally opens an HSA for an employee and makes employer contributions to the HSA. The guidance specifies several other activities that limit employees’ choices that would not be deemed to violate the “voluntary establishment” rule.

The 2006 guidance specifies, however, that an employer would convert an HSA into an ERISA plan if it received any discounts on non-HSA products from an HSA vendor, because that would constitute employer compensation. The DOL noted that such discounts may be prohibited transactions, as well. (See *Willis Employee Benefits Alert #88, DOL Issues Further Guidance on Health Savings Accounts* for additional information on the 2006 DOL guidance.)

#### *Wellness Programs*

### **Final HIPAA Nondiscrimination Regulations Include Rules for Wellness Programs**

Employee benefits developments at the end of 2006 included final regulations interpreting HIPAA’s nondiscrimination provisions. These final regulations apply for plan years starting on or after July 1, 2007. Although the final rules address a broadrange of ways in which group health plans may violate HIPAA by discriminating based on health factors, the provisions that are of greatest interest to most employers are those concerning wellness programs. The rules on wellness programs set the conditions under which group health plans may vary premiums and benefits based on health-factor-related achievements under wellness programs.

The new rules finalize a set of 2001 proposed rules on wellness programs. The biggest change from the proposed rules is the new rules’ identification of two types of wellness programs: those under which none of the criteria for obtaining a reward from a

health plan are related to one or more health factors and all others. Wellness programs of the first type are subject to very limited requirements. The second type is subject to stringent requirements that many will recognize from the proposed rules. Very generally, those requirements are:

- Rewards must be limited to 20 percent of the total cost of single coverage or the total cost of the coverage elected, if any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program;
- Each participant must have a chance to qualify for the reward at least once each year;
- The wellness program must be reasonably designed to promote good health or prevent disease;
- A reasonable alternative standard must be made available to those for whom it would be unreasonably difficult due to a medical condition, or medically inadvisable, to meet the generally applicable standard; and
- Health plan materials that describe the terms of the wellness program must disclose the availability of a reasonable alternative standard.

For additional information on the wellness program regulations, see *Willis Employee Benefits Alert #94, Final Nondiscrimination Regulations: How Do They Affect Wellness Programs?*

The final nondiscrimination regulations note that plan practices or provisions that are permitted under the nondiscrimination rules may nonetheless violate other laws. This provision was added in order to address concerns that some practices that comply with the nondiscrimination rules (e.g., a uniform exclusion of benefits for treatment of AIDS) might nonetheless violate the *Americans with Disabilities Act* (ADA).

#### *Wellness Programs*

### **The ADA: Impact on Wellness Programs**

Although wellness programs are becoming more prevalent in the workplace, they come with legal pitfalls and factors that must be considered before

implementation. At a meeting in 2006, it became clearer that one issue to consider is the ADA.

The Joint Committee on Employee Benefits of the American Bar Association (JCEB) meets with staff members of various regulatory agencies each year in order to discuss issues that are not clearly answered in available guidance. The JCEB's informal report on its 2006 session with the EEOC legal staff included the EEOC's response to a question regarding a plan that refused to cover anyone who would not complete a health risk assessment.

The EEOC concluded that this arrangement would involve employer medical inquiries that would violate the ADA. According to the EEOC, the program could not fit into an exception for voluntary wellness programs because the penalty of denying health coverage prevents the program from being voluntary. (For detailed information on how the ADA applies to wellness programs, see *Willis Employee Benefits Alert #80, Wellness Plans: HIPAA, the ADA and the EEOC*. Caution: Information in *Alert #80* regarding HIPAA nondiscrimination is out-of-date because the final nondiscrimination regulations noted above were issued after *Alert #80*.)

#### *Wellness Programs*

### **Willis Conducts Wellness and Disease Management Survey**

Earlier this year, Willis conducted a survey on wellness and disease management programs offered by employers. Over 400 companies participated in the survey. This survey provides findings from companies about their wellness and disease management programs that measure risk, promote compliance with physician recommendations, manage disease, and encourage healthy lifestyles.

Key findings from the survey include the following:

- Senior management is generally convinced that wellness programs are necessary and management is committed to improving employee health.

- Senior management is uncertain whether workers understand the correlation between their health and the costs of the underlying health plan.
- Management is undecided whether an employee's lifestyle (diet, smoking, etc.) should be tied to the cost of medical benefits for their employees.
- Management is optimistic about the return on investment in the long run.
- There is tremendous interest in offering new wellness programs and making improvements to existing plans.

The complete survey findings may be accessed by clicking on the following link: <http://team1.willis.com/benefitspractice/Documentation/Wellness%20and%20DM%20Survey%20final.pdf.pdf>

#### *Other Regulatory and Legislative Issues*

### **Medicare Part D: Annual Requirements for Plan Sponsors**

Medicare Part D imposes annual administrative requirements on plan sponsors, including plan sponsors who do not provide retiree health benefits. These obligations began in November 2005, and the first annual cycle was completed in 2006.

The Medicare Part D disclosure requirements were the first administrative obligations that most employers encountered in connection with Medicare Part D. These requirements apply to almost every health plan that provides prescription drug benefits to any Medicare Part D eligible individual. The rules require plans to provide notice, prior to or in response to five different events, of whether prescription drug coverage is or is not creditable. One of those events is the November 15th beginning of Medicare's Part D Annual Coordinated Election Period. The notice must be provided "prior to" that event — meaning that it must be provided at any time during the twelve months before November 15th. This "prior to" definition allows non-calendar year plans to distribute notices every year with their open enrollment materials rather than being tied to a November 15th schedule.

In addition to distributing notices regarding creditability of prescription drug coverage, the Medicare Part D rules require health plans to report that creditability status to CMS. Again, multiple events may trigger the filing requirement, but one trigger that applies every year is the start of the plan year. The report is required each year within 60 days after the first day of the plan year. (For reporting purposes, the plan year is the renewal or contract year.) Reporting is done electronically through the CMS website at [www.cms.hhs.gov/creditablecoverage/](http://www.cms.hhs.gov/creditablecoverage/). (For detailed information on the disclosure and filing requirements, see *Willis Employee Benefits Alert #84, Medicare Prescription Drug Annual Requirements*.)

#### *Other Regulatory and Legislative Issues* **States Expanding Dependent Eligibility**

There is a growing trend by state legislatures to pass laws requiring extended coverage for dependent children. Although most health insurance plans already provide dependent coverage up to age 19 with an extension to age 23 or 24 for full-time students, these new laws are requiring coverage for even older dependents. For example, one of these laws requires coverage of otherwise-eligible dependent children until they reach age 26 — regardless of whether the children are full-time students and another provides COBRA-type continuation coverage for children up to age 30. In some states, the extension is tied to special circumstances such as someone taking a medical or military leave of absence from school.

These legislative measures generally represent state efforts to reduce the growing number of uninsured. Currently, about 22 states have passed such laws or are considering them. Self-funded plans are generally unaffected by these state laws due to ERISA's preemption provision. Insured plans probably must comply because there is an exception to ERISA preemption for state insurance laws.

#### *Other Regulatory and Legislative Issues* **State 'Fair Share' Legislative Attempts**

Several states adopted "fair share" or "play or pay" laws in 2006 that would require employers to pay

certain taxes or fees unless they offer health coverage to their employees that meet minimum requirements. For example, Maryland passed a law that would have required companies with more than 10,000 employees in Maryland to either: (1) spend at least eight percent of payroll on health care; or (2) contribute the difference to the Maryland Medicaid Fund. Nevada and Massachusetts also adopted variations of fair share mandates, and several other states attempted to do so.

The Massachusetts mandate received a lot of attention in 2006 because it required that every Massachusetts resident obtain health insurance. The law also required employers having 11 or more full-time equivalent employees in Massachusetts to, among other things, make a "fair and reasonable" premium contribution to the health insurance of their employees or be subject to a \$295 per full-time employee annual assessment.

The good news for employers is that both a trial court and a court of appeals have held that Maryland's fair share law is preempted by ERISA. The court concluded that, unless ERISA preempts such legislation, employers could be subjected to 50 different state requirements and a "virtually limitless number of requirements that local subdivisions in each state may enact." Other legal challenges to these laws are anticipated.

#### *Other Regulatory and Legislative Issues* **Pension Protection Act of 2006**

This past summer Congress passed the Pension Protection Act of 2006 (PPA) that contained many new requirements for qualified retirement plans. Most of the new requirements apply only or primarily to defined benefit pension plans.

#### *Diversification Requirements for Defined Contribution Plans*

The PPA included some provisions affecting defined contribution plans including one that deals with the diversification requirements that apply to certain defined contribution plans that have investments in publicly traded employer securities. The new rules require such plans to permit participants to diversify their accounts' investments in publicly traded

employer securities. The PPA rules also require such plans to provide notice to participants of that ability to diversify. In November, the IRS provided transitional guidance on the diversification requirements, including a model notice. (For detailed information on the IRS guidance, including the model notice, please refer to *Willis Employee Benefits Alert #90, Diversification Requirements for Defined Contribution Plans – Action Required and Model Notice Included*.)

#### *Corporate Owned Life Insurance*

While the PPA primarily addressed retirement issues, it also included provisions affecting corporate-owned life insurance (COLI). These are policies that a company takes out on the lives of its employees with the company as the beneficiary of the policy. Some of the advantages to companies are that the increase in cash value accrues tax-free to the employer while the policy is in force, companies can borrow against the cash value, and proceeds paid upon the death of the employee are tax-free.

The PPA made it more difficult for employers to receive death benefits from COLI on a tax-free basis. For policies issued August 17, 2006 and later, it is still possible for an employer to receive all policy proceeds of COLI on a tax-free basis, but several conditions must first be met. These include:

- The insured must have been employed within the 12 months before his or her death or have been a director or highly compensated employee at the time the policy was issued;
- The employer must provide written notice about the policy to the insured; and
- The insured must have provided consent before the policy was issued.

Additional information on COLI and the new PPA requirements may be found in *Willis Employee Benefits Alert #90, COLI: Pension Protection Act Adds Several Conditions*.

#### *Other Regulatory and Legislative Issues*

##### **Debit Cards and Flex Spending Accounts: New IRS Guidance**

The IRS published two sets of guidance in 2006 concerning use of debit, credit, or other electronic payment cards to access flexible spending account funds. The first was intended to clarify and expand the circumstances in which the cards could be used to pay for purchases. It was also intended to reduce the circumstances in which participants were required to provide receipts or other substantiation to the plan after the purchase to demonstrate that the cards were used only for qualifying medical expenses. The second release of IRS guidance on this topic includes a transition rule that allows certain retailers to continue accepting the cards for payments during 2007 even though the retailer does not yet meet the requirements of the new guidance. (For additional details, see *Willis Employee Benefits Alert #75, Debit Cards and Flex Spending Accounts: IRS Expands Substantiation Requirements*. A future *Alert* will cover the second piece of IRS guidance.)

#### *Other Regulatory and Legislative Issues*

##### **IRS Issues Proposed Regulations On Expenses Reimbursable By DCAPs**

Early in 2006, the IRS published proposed regulations that affect which expenses can be reimbursed tax-free by an employer-sponsored dependent care assistance program (DCAP). DCAPs usually are offered as cafeteria plan benefits, and are also often referred to as dependent care flexible spending accounts, or dependent care FSAs. The new guidance describes what expenses are eligible for the federal dependent care tax credit (DCTC). The guidance affects DCAPs because DCAPs generally can reimburse expenses that would qualify for the DCTC.

The proposed rules provide important clarifications with respect to certain key issues like when expenses are deemed primarily for care (as opposed to education), when transportation costs

can be counted as dependent care expenses, and when day camp expenses may be reimbursed. The proposed regulations also clarify a variety of other issues that should make administration of DCAPs easier. (For additional details, see *Willis Employee Benefits Alert #72, IRS Issues Proposed Regulations Governing DCAPs*.)

#### *Other Regulatory and Legislative Issues*

### **Final USERRA Regulations Address Benefits Issues**

Final USERRA regulations became effective early in 2006. The regulations address a broad range of topics under USERRA and include provisions relating to employers' obligations to continue benefits for those on military leave and to reinstate benefits for those who return from military leave. In the continuing benefits category, the regulations include provisions interpreting USERRA's requirement that employers allow a COBRA-like

opportunity to continue health coverage for up to 24 months during military leave.

Although the USERRA continuation opportunity is similar to COBRA, it is not identical. For example, unlike COBRA, USERRA does not specify minimum periods that must be allowed for employees to elect and pay for continuation coverage. The regulations confirm that employers may adopt reasonable election and payment procedures (including deadlines) with respect to USERRA continuation coverage, and subject to several exceptions, terminate coverage of employees who do not elect or pay for USERRA continuation according to those procedures. Under the final regulations, employers that do not adopt such procedures will be particularly vulnerable to significant retroactive COBRA obligations. (For more details, see *Willis Employee Benefits Alert #57, Final USERRA Regulations: Required Steps for Employer Compliance*.)

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