EMPLOYEE BENEFITS
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A LOOK BACK: 2007 EMPLOYEE BENEFITS DEVELOPMENTS

To help put the past year into perspective, we offer a look back at some of the key employee benefits developments that we covered in Willis publications during 2007.

We lead with an event that employee benefits professionals had anticipated for decades: new proposed cafeteria plan regulations. We then review several key developments related to state and local laws intended to expand healthcare coverage, and court decisions regarding ERISA preemption of those laws. We also look at:

- State and federal healthcare reform proposals
- Employers' use of consumerism and wellness programs, and legal developments affecting those programs
- Other regulatory developments, including updates on employer obligations under Medicare Part D

If you would like more information about any of these issues, please contact your local Willis office.

PROPOSED CAFETERIA PLAN REGULATIONS

The Internal Revenue Service (IRS) issued proposed cafeteria plan regulations in August. The proposal incorporated decades of proposed and temporary regulations, IRS and court rulings on various issues, informal IRS guidance and the many intervening statutory changes. With a few exceptions, the new cafeteria plan regulations are only proposed, meaning they are not legally binding now. But the IRS took pains to demonstrate that the new rules primarily restate or clarify existing guidance. (Final cafeteria

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plan regulations were already in effect on two topics: mid-year election changes and the interaction between cafeteria plans and the Family and Medical Leave Act. Nothing in the proposed regulations revised these.)

While there were no fundamental changes for cafeteria plans, the proposed regulations clarified many items and made a number of incremental changes. Some items of note include:

- **PLAN DOCUMENT**
  A cafeteria plan must be in writing, must be formally adopted by the sponsoring employer and must include certain provisions. No written plan means no cafeteria plan, and an employee's election of benefits would result in taxable income the employee would otherwise have been able to avoid. While these requirements are not new, they are emphasized in the regulations.

- **NONDISCRIMINATION**
  The new rules provide details on the requirement that cafeteria plans must not discriminate in favor of highly compensated employees. The IRS had not previously issued any official guidance in any form on nondiscrimination testing.

- **GROUP TERM LIFE INSURANCE**
  One provision that was effective immediately (August 6, 2007) is that imputed income attributable to group term life insurance over $50,000 is based solely on Table I rates (instead of the higher of Table I rates vs. actual cost) for group term life insurance purchased through a cafeteria plan.

- **INDIVIDUAL INSURANCE PREMIUM PAYMENTS**
  The rules confirm that cafeteria plans can allow employees to elect individual accident or health insurance coverage or elect COBRA coverage under which they are covered employees and therefore pay premiums on a pre-tax basis. The rules explicitly prohibit, however, the use of health FSAs to pay insurance premiums, reinforcing a long-standing IRS position.

- **DERERRAL OF INCOME**
  While cafeteria plans generally may not operate in any manner that permits employees to defer the receipt of income to another year, these regulations confirm that certain deferrals are permitted. For example, salary reduction amounts taken during the last month of the plan year can be applied to pay premiums for the first month of the next plan year. Also, required orthodontia prepayments made before services begin may be reimbursed by a health FSA.

For a more complete description of the proposed cafeteria plan rules, please see *Employee Benefits Alert*, Issue 116, "IRS Releases Proposed Cafeteria Plan Regulations."

Shortly after the IRS released the proposed cafeteria plan regulations, it issued final regulations that defined, in part, the expenses that can be reimbursed by a cafeteria plan's dependent care flexible spending arrangement (DCAP). These rules specify that summer school and tutoring programs are educational and therefore the cost is not reimbursable; that the payments for specialty day camps (such as computer camps) may be reimbursable; and that dependent care fees incurred during short temporary absences from day care may be reimbursable. Further information about these regulations may also be found in *Employee Benefits Alert*, Issue 116, "IRS Releases Proposed Cafeteria Plan Regulations."

STATE AND LOCAL HEALTHCARE REFORM LAWS

THE MASSACHUSETTS HEALTH CARE REFORM ACT

The Massachusetts Health Care Reform Act (HCRA), an example of a play-or-pay law, went into effect July 1. The law imposes an annual fair share contribution obligation on employers that do not make a "fair and reasonable" contribution toward employees' healthcare coverage. While the amount of the fair share contribution obligation is a moderate $295 per employee, many believe that this amount will increase. In addition to the fair share contribution, the HCRA also requires employers to maintain cafeteria plans that provide for employees to pay premiums for outside coverage on a pre-tax basis, raising significant federal compliance issues for employers.

Perhaps even more daunting, the HCRA requires extensive reporting from employers, including:

- Submission of an annual report, including the Health Insurance Responsibility Disclosure (HIRD) form, to the Division of Unemployment Assistance in connection with the fair share contribution requirement
- Collection and retention of a HIRD form from each employee who declines to enroll in the employer's health plan or who declines to use the employer's cafeteria plan to purchase insurance on a pre-tax basis
- Provision of an annual MA 1099-HC form to each employee who resides in Massachusetts and is covered under the employer's health plan
- Provision of an employer's cafeteria plan to the state upon request

For detailed information about the Massachusetts law and its requirements, see *Employee Benefits Alert*, Issue 110, "The Massachusetts Health Care Reform Act: What's an Employer to Do" Issue 117, "Massachusetts Healthcare Reform: Employer Reporting Obligations;" and Issue 122, "Update on Reporting Obligations under the Massachusetts Health Care Reform Act."

SAN FRANCISCO'S HEALTH CARE SECURITY ORDINANCE

City governments have also enacted legislation mandating healthcare coverage. Most famously, San Francisco enacted the Health Care Security Ordinance (HCSO), with an initial effective date of July 1, 2007. The HCSO was subsequently amended to delay its effective date until January 1, 2008 (April 1, 2008 for employers with 20-49 employees). The HCSO requires minimum contributions of $1.76 per hour worked from employers with 100 or more employees and $1.17 per hour from those with 20-99 employees. See *Employee Benefits Alert*, Issue 112, "San Francisco Delays Health Care Security Ordinance Effective Date" for further information. Additional information on the HCSO's requirements is available in Willis' *EB News Flash*, December 12, 2007: "San Francisco's Mandated Coverage Ordinance – What to Do By January 1, 2008" (available from your local Willis office).

ERISA PREEMPTION OF STATE AND LOCAL PLAY-OR-PAY LAWS

In the first half of 2007, two federal court decisions gave employers hope that the Massachusetts and San Francisco laws would be set aside before they became effective. First, the Fourth Circuit Court of Appeals held that ERISA preempted a Maryland law that required certain employers to devote a minimum amount to providing health benefits or to pay that amount to the state. Then, a lower court held that a similar requirement imposed by Suffolk County in New York

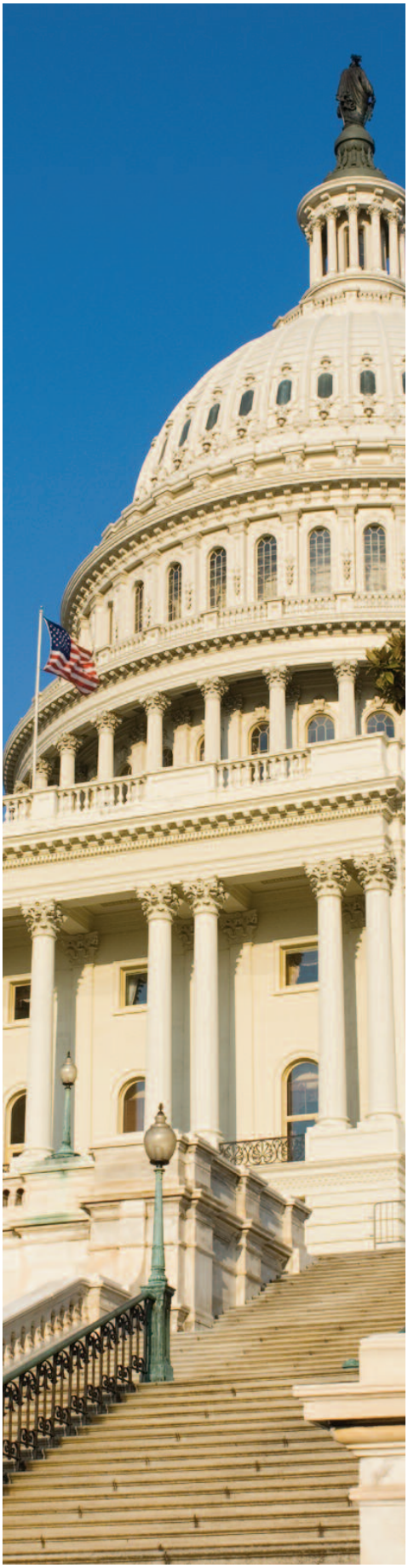
also was preempted, even though, compared to the Maryland law, it provided employers additional compliance options.

A challenge to the employer contribution requirements of San Francisco's HCSO initially met with similar success in late December when, days before its effective date, a federal district court ruled that the HCSO's minimum employer contribution provision was preempted by ERISA and that the city could not enforce it. The city immediately appealed and, on January 9, 2008, the U.S. Court of Appeals for the Ninth Circuit stayed the district court's injunction against implementation of the HCSO, which means that the HCSO will be in effect while the appeal is being heard. The Court of Appeals did not reverse the district court's ERISA preemption holding; it only stayed the portion of the district court's ruling that prevented the city from enforcing the HCSO during the appeal. Even so, the Court of Appeals signaled that it is likely to find that ERISA does not preempt the HCSO. The court based entry of the stay on several factors, including the city's showing a "strong likelihood" of success in its appeal. For additional information on these decisions, see Willis' *EB News Flash*, December 27, 2007, "Court Holds That San Francisco's Mandated Coverage Ordinance is Preempted," and *EB News Flash*, January 11, 2008, "Appeals Court Rules that San Francisco Can Enforce Its Employer Contribution Mandate" (both available from your local Willis office).

For additional information on ERISA preemption, see *Executive Signal,* Issue 6, "ERISA Preemption: What Is It, and Why Is It Important?"

STATE CAFETERIA PLAN MANDATES

In addition to major healthcare reform proposals like those enacted by Massachusetts and San Francisco, some states (such as Massachusetts, Connecticut, Missouri and Rhode Island) have mandated that employers sponsor cafeteria plans that allow employees to pay their healthcare premiums on a pre-tax basis. These laws raise particularly difficult compliance issues under federal laws. See *Employee Benefits Alert*, Issue 121, "States Mandate Cafeteria Plans – Effect on Employers Unclear."



FEDERAL AND STATE HEALTHCARE REFORM PROPOSALS

FEDERAL HEALTHCARE PROPOSALS

National healthcare proposals have been set forth by various coalition groups, federal legislators and the 2008 presidential candidates. For a summary of the proposals, see *Executive Signal,* Issue 1, "Federal Healthcare Reform in 2007: Deal or No Deal?" To date, Congress has not enacted any federal reform proposal.

Early in 2007, President Bush proposed a $7,500 (single) or $15,000 (family) standard tax deduction for anyone who purchased health insurance on their own or through an employer. Those with employer-provided coverage would receive the standard tax deduction; any value of employer-provided coverage in excess of the standard deduction would be taxed. For additional information, please see *Employee Benefits Alert*, Issue 95, "President Bush Announces Broad Health Benefits Proposal."

The prospects for healthcare reform on a national level remain uncertain, at best.

STATE HEALTHCARE PROPOSALS

Fueled in part by the increasing drain the uninsured are having on limited state resources, the successful passage of healthcare reform legislation in Massachusetts, and the lack of progress by the federal government in finding a healthcare solution, state governments are under increasing pressure to act. There have been highly publicized healthcare reform proposals from several states (including California, Pennsylvania and Illinois), all intended to provide affordable universal healthcare coverage for state residents.

As 2007 ended, discussion of these proposals among legislators continued. It is likely that these efforts will continue in 2008 although their future is uncertain. For example, while the California State Assembly recently enacted the first phase of universal healthcare, the Senate Health Committee, citing concerns about the measure's multibillion dollar cost, voted against the proposal. The committee's action precludes a Senate vote on the measure. Governor Schwarzenegger vowed to continue his strong support of the healthcare proposal. For more information about state healthcare reforms, see *Executive Signal,* Issue 4, "Where Federal Legislators Fear to Tread."

CONSUMERISM, WELLNESS AND HEALTHCARE BENEFITS

THE CALL OF CONSUMERISM

Numerous surveys report that voters with health insurance are deeply concerned with curbing skyrocketing healthcare costs. One contributor to the high cost of healthcare is that many employees with medical insurance have long been insulated from the actual costs of medical services. Neither doctors nor patients have had much incentive to keep costs down, and some observers believe that as much as 20 percent of all care is unnecessary and simply inflates our national healthcare bill. Involving consumers in the financial consequences of healthcare decisions is an increasingly popular and effective option for employers. This will naturally contribute to the proliferation of high-deductible health plans and other healthcare

options, such as health reimbursement arrangements (HRAs) and health savings accounts (HSAs).

Other cost-control tactics include wellness plans. We expect wellness plan usage to double over the next three years. Biometric screenings will soon be the norm and smart employers will be drawn to sophisticated programs with demonstrable return on investment. Employees will continue to shoulder their share of healthcare expenses and are expected to become more accepting of their individual responsibility for healthcare costs. Employers are in a unique position to influence employee behavior. For more information, please refer to *Executive Signal,* Issue 2, "Healthcare Costs and Benefits: A Glance Ahead."

THE 2007 WILLIS WELLNESS SURVEY

To determine how employers are utilizing wellness benefits, Willis conducted its second annual wellness survey. Over 400 companies responded to the 2007 survey, which focused on program design; perception and satisfaction with wellness programs; success stories from companies that provided wellness programs; and recommendations from employers about how to implement or improve wellness programs.

The survey indicated that employers are seeing real results; lives and not just dollars are being saved. There is a trend toward expanding wellness programs to include family members and while return on investment (ROI) is important, management evaluates program success by more than ROI. There is tremendous interest in offering new wellness programs or improving existing plans. Please contact your local Willis office to receive a complimentary copy of the full survey report.

THE WELLNESS INCENTIVE RESTRICTIONS LOOPHOLE AND ITS CLOSURE

Many wellness programs include incentives employees can earn by meeting wellness goals, such as not smoking. Under HIPAA's nondiscrimination requirements, such incentives are permitted only if the health plan offers certain individuals alternative methods of earning the incentive and limits the maximum incentive for meeting the wellness goals. Employers often object to HIPAA's nondiscrimination requirements, believing that they undercut the ability of programs to change employee behavior.

Responding to these objections, some health insurance vendors began offering wellness programs that they claimed were exempt from HIPAA's nondiscrimination rules. These vendors structured policies to fit within HIPAA's exemption for "supplemental" insurance coverage that is "similar" to Medigap and certain other supplementary coverage. Some experts believed that employers could use this language to establish a separate supplemental plan that could be provided free to employees who met health standards and at a cost to others. Creating such an offering to supplement a plan with a very high deductible provides strong behavioral incentives.

Analysis by Willis' Legal & Research Group suggested that such programs would not withstand government scrutiny. Subsequently, the DOL issued guidance establishing a safe-harbor definition for a supplemental insurance program and warned that plans, such as the supplemental programs described above, that do not meet its criteria may be subject to enforcement action. For further information, please see *Employee Benefits Alert*, Issue 113, "Wellness Incentive Restrictions – Is There Really a Loophole?" and Issue 123, "DOL Closes a Loophole in Requirements for Wellness Programs."

HSA ROLLOVER GUIDANCE

In December 2006, Congress authorized "qualified HSA distributions," which are transfers of HRA and health FSA balances into HSAs. This rollover opportunity is limited, however. A qualified HSA distribution is a one-time event for each HRA or health FSA, must be completed before January 1, 2012, and cannot exceed the HRA or health FSA balance on September 21, 2006 or, if lower, the balance on the date of the distribution.

The IRS issued guidance in 2007 that explained the conditions that must be met in order for a qualified HSA distribution to occur. Among other requirements, the plan document must be amended by the last day of the plan year to allow for a qualified HSA distribution at the end of that year. In addition, the employer must make the distribution directly to the HSA trustee by the 15th day of the third month of the next plan year, but only after the employee becomes eligible to receive HSA contributions. Refer to *Employee Benefits Alert*, Issue 102, "HSA Rollover Guidance Helps Plan Sponsors Switch From HRAs to HSAs" for more information.

PROPOSED RULES ADDRESS TWO HSA COMPARABLE CONTRIBUTION ISSUES

The IRS also issued proposed regulations regarding one aspect of an employer's obligation to make comparable HSA contributions. Employers who make their HSA contributions through a Section 125 cafeteria plan (or who allow employees to make pre-tax contributions to their HSAs through a Section 125 cafeteria plan) are not subject to the comparability requirements and will not be affected by these new proposed regulations. The proposed regulations explain how the comparability rules apply if an employee has not established his or her HSA on a timely basis. The rules also address the circumstances under which an employer may accelerate its contributions to an employee's HSA and still comply with the comparability rules. Please see *EB News Flash*, June 6, 2007, "IRS Issues Proposed Regulations Regarding Comparable HSA Contributions" (available from your local Willis office).

OTHER REGULATORY DEVELOPMENTS

TRICARE SECONDARY PAYER RULES

Effective January 1, 2008, group health plans are prohibited from offering any financial or other incentives to decline enrollment in a group health plan that would provide primary coverage relative to TRICARE (the healthcare plan for US military personnel and their dependents). TRICARE-eligible employees must be given the same opportunities to participate in a plan as similarly situated non-TRICARE-eligible employees. Similar rules apply with respect to Medicare under Medicare Secondary Payer (MSP) rules and, in that context, rules have been developed that allow opt-out bonuses and certain other cafeteria plan provisions to apply to Medicare-eligible employees, so long as those items are available to all individuals who are eligible for an employer's plan.

Congress asked the Department of Defense (DoD), the agency that administers TRICARE, to report to Congress on the extent to which the DoD would adopt the MSP rules that allow opt-out bonuses with respect to TRICARE. In July, the DoD reported as requested and said that it expected to issue regulations shortly, and that its regulations would closely parallel the MSP rules on employer incentives. For more information, please see *EB News Flash*, July 25, 2007, "Medicare Secondary Rules Will Provide the Pattern for TRICARE Secondary Rules" (available from your local Willis office).

RDS RECONCILIATION PROCESS

The Retiree Drug Subsidy (RDS) program, which began in 2006 when Medicare added its prescription drug benefit, makes payments to plan sponsors that provide equivalent prescription drug coverage to qualifying retirees who do not enroll in Medicare's prescription drug program. In June, the Centers for Medicare and Medicaid Services (CMS) announced the 12-step reconciliation process that applies to plan sponsors that enrolled in the RDS program and received subsidy payments. Most employers will not be affected by this guidance but employers who participate in this program must complete a final reconciliation. The reconciliation for 2006 calendar year plans is due no later than March 31, 2008. For more information, see *EB News Flash*, June 25, 2007, "RDS Reconciliation Process – The Other 12-Step Program" (available from your local Willis office).

CMS REVISES MODEL DISCLOSURE NOTICES

The Centers for Medicare and Medicaid Services (CMS) revised its model prescription drug disclosure notices again in 2007. These are the notices that plan sponsors are required to provide to certain individuals in connection with Medicare Part D (Medicare's prescription drug program) explaining whether the plan's prescription drug coverage is "creditable." This was the third revision of the model notices in as many years. The 2007 changes were very minor but CMS expected plan sponsors to use the new model notices effective February 15, 2007. For further information about the disclosure notice requirements, please refer to *Employee Benefits Alert*, Issue 104, "CMS Revises Model Prescription Drug Disclosure Notices (Again!)."

One model notice included a sentence that should have been omitted and CMS recommends that plan sponsors remove this sentence. For more information about the erroneous model notice and how to fix it, see *Employee Benefits Alert*, Issue 118, "Checklist: Notices to Include in Health Plan Annual Enrollment Materials."

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