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Bush Signs Pension Reform Bill

On August 17, President Bush signed into law the *Pension Protection Act of 2006* (PPA). *The Wall Street Journal* quotes the President as stating: "Members of both parties came together to pass a good bill that will improve our pension system, while expanding opportunities for Americans to build their own nest eggs for retirement."

The PPA's main intent is to make sure that employers improve how they value and fund their defined benefit pension duties. Many pension plans rely on group annuities as a means of funding — giving life insurers a reason to be concerned about the PPA's pension safeguard measures. The legislation also defines marketing standards for corporate-owned life insurance, facilitates automatic 401(k) enrollment, and improves how advisors counsel participants about plans.

There has been broad support in Congress for toughening funding rules and protecting the Pension Benefit Guaranty Corporation's (PBGC) ability to take over defunct plans. The PBGC currently has a nearly \$23 billion deficit. Legislative conferees had been trying for months to resolve differences in bills passed last year by the House and Senate.

HSA Comparable Contributions: Final Regulations

Health Savings Accounts (HSAs) were introduced as part of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* and quickly became an important employer option within consumer directed health plans. Some sources suggest that HSAs are overtaking Health Reimbursement Arrangements (HRAs) as the preferred employer option.

HSAs are tax-favored accounts that employees may use to pay for their medical expenses. HSA tax benefits include pre-tax contributions, tax-free growth, and tax-free distributions for qualified medical expenses. However, HSAs are also saddled with numerous requirements and restrictions. Among other things, they *must* be coupled with a high deductible health plan (HDHP) that satisfies strict design requirements. Other limiting rules apply, such as employer contributions to an HSA must be "comparable" for all comparable participating employees.

Failure to make comparable contributions can result in a steep (35 percent) excise tax on the contributions.

The IRS released final regulations that make possible greater contribution differentiation and increase funding flexibility. The new regulations clarify the use of a cafeteria plan to deliver matching or incentive HSA contributions that might not otherwise be considered comparable. They also define who is an employee for purposes of the comparability calculations.

Changes outlined in the new guidance expand options from single and family coverage to:

- Self only,
- Self plus one,
- Self plus two, and
- Self plus three or more.

Testing for each coverage program is conducted independently. However, the employer contribution cannot be any less for the self plus two coverage option than it is for the self plus one coverage option. Likewise, the employer contribution cannot be any less for the self plus three coverage option than it is for the self plus two coverage option.

The regulations also clarify that employer contributions made through a cafeteria plan can be excluded from the comparability calculations if workers have the right to elect cash or other taxable benefits in lieu of all or a portion of the HSA contribution — regardless of whether the employee actually participates in the HSA. Of course, employer contributions made through a cafeteria plan remain subject to discrimination tests set forth under Section 125 of the Internal Revenue Code.

Finally, collectively bargained employees do not have to be considered as employees. This generally parallels long established discrimination testing rules which exclude union employees from testing. Contributions on behalf of independent contractors, sole proprietors and partners who are not employees can also be excluded.

The regulations are effective immediately, but will apply to HSA contributions on or after January 1, 2007. The IRS final regulations can be found at:

www.americanbenefitscouncil.org/documents/irs_regs_comparability_073106.pdf .

Changes to the Form 5500 Filing

Last July, the Department of Labor, Department of Treasury and the Pension Benefit Guaranty Corporation issued proposed revisions to the Form 5500. The proposed changes would significantly modify the content of the Form 5500 as well as the process for filing. When adopted, the proposed revisions would apply to plan years beginning on or after January 1, 2008.

The substantive changes that impact health and welfare plan filings are:

Schedule A includes critical information about each insured benefit under the plan. Because many plan sponsors continue to have difficulty obtaining the information from insurance carriers necessary to complete the Schedule A, a check box will be added to the Schedule A which will allow the plan sponsor to note when the insurer failed to provide the necessary information. Additionally, space will be provided on the form for the filer to describe the type of information that was not provided by the insurer.

Schedule C includes service provider information. The proposed revisions significantly increase the reporting requirements for plan-related fees and expenses reported on this Schedule. The schedule will be divided into three parts:

- Part I will require the identification of each person who received \$5,000 or more (from any source) in compensation related to services for the plan. If any person receives more than \$1,000 from a party other than the plan or the plan sponsor, then the source of that compensation must be reported.
- Part II will allow space for the plan to identify fiduciaries or service providers who failed – or refused – to provide information about their compensation. The proposed revisions address the reporting of income paid to non-fiduciary employees of the plan and, in addition, update the codes for identifying services. The proposal outlines that reportable compensation will include brokerage commissions and fees charged to the plan.
- Part III will not be modified and will outline termination information on accountants and enrolled actuaries.

Schedules H and I will include a question asking whether the plan has failed to pay any benefits due during the plan year.

Schedule I will also request enhanced information regarding administrative expenses paid by small plans. This line item entry will be listed separately from other expenses of operating the plan.

The 5500 Form will also require filers to indicate the number of participating employers if a multiemployer plan exists.

For ERISA plan years beginning on or after January 1, 2008, Form 5500 filers will be required to file electronically. The proposed Form 5500 instructions emphasize the administrator's duty of recordkeeping and the plan administrator's obligation to make the latest annual report available for examination. Even after plans are required to file electronically, plan administrators must maintain a signed, printed copy of each completed filing.

Massachusetts Health Care Mandate

In April 2006, Massachusetts Governor Mitt Romney (R) signed important health care legislation into law. The legislation requires every resident in the state to obtain health insurance, either on their own or through another entity, by July 1, 2007. A failure to do so will result in the forfeiture of their individual state tax exemptions as well as fines.

According to *Managed Care Week*, top officials from Massachusetts are saying that resulting health insurance products will have premiums of about \$200 a month. Speaking at the annual conference of America's Health Insurance Plans, Governor Romney said that premiums on these new products will range from \$150 to \$250 per month. The state has proposed a variety of ways to lower the premium below \$350 (the average premium paid in the small-group market). Such proposals include narrowing the choice of providers or expanding the use of Health Savings Accounts and high deductible health plans.

Now that Massachusetts has started releasing details about the law, health insurers will have the information they need to begin seriously pricing their products. For additional information about the Massachusetts law, please see *Willis EB Alert #79*.



Court Overturns Maryland's "Wal-Mart Health Care Law"

A federal court has overturned Maryland's *Fair Share Health Care Fund Act*. That law would have required Wal-Mart Stores, Inc. to spend more on employee health care. The court overturned the law and specifically noted that the retailer "faces threatened injury" from the law's spending requirement. Although other states have considered similar bills, no other state has adopted one. In Maryland, where state auditors were looking for ways to rein in a \$4.6 billion annual Medicaid bill, the Wal-Mart law was seen as a way to encourage companies to keep workers off the public program.

Background

Last January, Maryland lawmakers overrode Governor Bob Ehrlich's (R) veto of the *Fair Share Health Care Fund Act*. The law would have required companies with more than 10,000 employees in Maryland to either: spend at least eight percent of payroll on health care or contribute the difference to the Maryland Medicaid Fund. Proceeds from these fines would have been used to fund the state's health program for the poor.

Proponents of the law characterized the measure as an attempt to stem the tide of ever-increasing Medicaid costs. It had been widely reported that only four employers in Maryland (Wal-Mart, Johns Hopkins University, Northrop Grumman, and Giant Food Stores, Inc.) employed more than 10,000 workers — and that only Wal-Mart failed to meet the eight percent threshold. This is why the media dubbed the legislation the "Wal-Mart law". The law would have had a January 1, 2007 effective date.

Legislators in dozens of other states have proposed similar bills in the past year. So far, these so-called "pay or play" mandates have generally failed, but some legislative observers expressed fear that enactment of the Maryland law might shift legislative momentum against employers.

Arguments

Employee benefit laws are governed by ERISA which contains a broad provision that overrides those state laws that touch on the subject of employee benefits or that require employers to take certain benefit actions. Wal-Mart, through a retailing association, argued that Maryland intruded into an area of law reserved to the federal government.

According to the January 9, 2006 opinion of Joseph Curran (D), Maryland's Attorney General, the *Fair Share Act* would not be preempted by ERISA since the law did not specifically refer to or regulate employee welfare benefit plans. Curran's now rejected argument had been predicated on the idea that despite the law, the employer is still free to choose to spend no percent of its payroll on health-related expenses for its employees and pay the resulting assessment. Some experts thought that the law might survive an ERISA preemption challenge if viewed as a payroll tax rather than a mandate.

Decision

The Federal District Court in Maryland ultimately held that Maryland's *Fair Share Act* violated the main objective of ERISA's preemption clause by creating spending requirements that are not applicable in most other jurisdictions. The court further concluded that unless such legislation is deemed to be preempted, employers potentially will face not only 50 different state requirements, but a "virtually limitless number of requirements that local subdivisions in each state may enact."

This issue is expected to continue to play out further in the courts. The Maryland Attorney General published the following statement the day after Wal-Mart prevailed in its Federal Court challenge:

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“We respectfully disagree with the court’s determination on several counts. As to the substantive ground, we think the court erred in finding that the law is preempted by ERISA. Instead, as we argued to the court, Supreme Court precedent makes it clear that this law does not impermissibly impact health benefit plans. Employers may choose to pay the tax or avoid paying the tax in several ways. We do agree that the court’s conclusion is correct that the law does not violate equal protection.

We have 30 days to note an appeal and of course, expect to do so, consistent with our responsibility to zealously defend the laws of the State.”

Reducing Wait Time

The *Wall Street Journal* reports that new, innovative programs are helping doctors redesign their offices to squeeze more profit out of their practices and give patients better access to medical services. Surveys show that patients are becoming increasingly frustrated with delays to get appointments, hours in the waiting room, too-brief visits with the doctor, and the near impossibility of getting the physician on the phone. Although the goal is to improve care, the programs also aim to avert a looming shortage of primary-care doctors.

The new programs borrow lessons from other industries to help doctors work more efficiently. One approach uses calculations developed by airlines, hotels and restaurants to predict demand. Others involve simple changes, such as leaving afternoon appointments open for urgent visits or having patients fill out paperwork online, ahead of time.

Kaiser Permanente recently introduced a program to help 12,000 doctors who contract with its health plan, to increase their efficiency with a new electronic medical records system. Other electronic medical records models involve more fundamental change, such as one called “ideal micro practice” that sharply reduces or even eliminates support staff. With this design, doctors rely on electronic health records and practice-management software to quickly dispense with administrative tasks.

Doctors often cite high overhead costs as a reason that it is difficult to introduce helpful but expensive new technology. However, less expensive electronic medical records systems are becoming more readily available. The federal Center for Medicare and Medicaid Services is funding a program — known as Quality Improvement Organizations — to help 4,000 practices adopt electronic patient records.

Additionally, more than 4,000 medical professionals have attended practice-redesign summits held by the nonprofit Institute for Healthcare Improvement. Such programs show doctors how to predict supply and demand and use new software tools to minimize patient wait time. “Open access” programs help doctors calculate the demand for appointments using formulas based on the number of patients in their practice and an average no-show rate. That differs from current practice where doctors may book appointments three months in advance, often leading to out-of-control patient traffic in the office and no spare time for urgent cases.

The *Wall Street Journal* article also noted the following tools that smaller practices are implementing to improve patient care:

- *Reducing or eliminating office staff* — Lower overhead allows doctors to afford longer, more meaningful visits.
- *Practice Web sites* — Patients can download and complete forms prior to the office visit as well as ask non-urgent questions via secure email.
- *Electronic medical records/practice-management software* — Patients can receive alerts and reminders about follow-up care.

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And the Survey Says...

UnitedHealth Group recently released the results of a three-year study that suggested consumer-driven health plan (CDHP) enrollees can cut their overall health care costs. The study also indicated CDHP members were more likely to manage their health than enrollees in traditional health plans.

When comparing cost and utilization to those enrolled in a sample of preferred provider organizations (PPOs) it appears consumer behavior is affected with enrollees becoming more attentive to their health care needs. This represents good news for employers hoping to adopt a CDHP strategy as a mechanism to adjust the way workers think about benefits.

The UnitedHealth Group study indicated that CDHP member costs decreased between three and five percent over 2004 and 2005. By contrast, costs for PPO enrollees increased by eight to ten percent. CDHP enrollees also sought preventive care five percent more often than PPO enrollees.

When comparing use of acute care services, CDHP members were found to have 22 percent fewer hospital admissions and 14 percent fewer emergency room visits. The same held true according to the survey for chronically ill CDHP enrollees; with eight percent fewer hospital admissions and 12 percent fewer emergency room visits than PPO members.

The study also touched on Health Savings Accounts (HSAs) by looking at 130,000 members with HSAs. The average balance for accounts opened in 2005 was slightly more than \$1,100. Employer contribution was shown to be a critical component to employee contribution. About 90 percent of employees opened an HSA if their employer contributed while only 27 percent contributed without the employer's participation. Overall 60 percent of employers studied contributed to their employees' HSAs.

In contrast, a study published in the policy journal, *Health Affairs*, reported that HSAs and their accompanying HDHPs will not reduce cost. According to the article's authors, this appears to be due to the fact that these plans do not significantly increase out-of-pocket costs for policyholders who spend the most on medical bills.

The *Health Affairs* study indicated that those truly ill — responsible for the most health care expenditures — do not recognize the higher costs and so do little to reduce overall cost of health care in the United States. Commenting further, the authors concluded the effect of HSAs and the HDHPs that must accompany them will depend on the actual provisions of the plans and of the plans they replace.

Tougher Executive Comp Disclosure Coming?

The *Wall Street Journal* reports that Congress and federal regulators will require businesses to be more vigilant about determining and reporting executive compensation.

The Securities and Exchange Commission has submitted proposals for public comment that would create very specific guidelines for consistent reporting of total executive compensation. Some of the new initiatives would require precise valuation of perks, reporting of deferred compensation and potential retirement payments, and reporting of employees who make more money than executives named in the compensation report. As a result, departments will have to collaborate in order to obtain the most accurate report possible, and consult with outside experts for some of the more obscure calculations. The new regulations may also force companies to show a stronger link between executive earnings and company performance.

Hawaii: Health Care Paradise?

According to the publication *Best's Review*, Hawaii's *Prepaid Health Care Act* is in serious need of change. The law generally requires employers to offer health insurance to all employees who work more than 20 hours per week. The state's unique program has kept Hawaii's rate of uninsured residents relatively low and stable for years. However, insurers and businesses are concerned that the law effectively overcharges employers for healthcare premiums and inhibits competition and innovation among the insurers that serve the state.

In addition, it is difficult for the state legislature to change the law because it was initially passed through a special ERISA exemption and would require a second exemption to make any major changes. The ERISA restriction creates an almost insurmountable legislative roadblock. For example, the legislature cannot lift the 1.5 percent cap on employee contributions to healthcare premiums. As a result, employers' contributions have risen disproportionately with inflation over the years. According to some legislative observers, the law's narrow definition of what types of health plans are acceptable prevents insurers from offering variations such as health savings accounts.

FMLA Enforcement Complaints Declined

According to the Department of Labor, the number of *Family and Medical Leave Act* (FMLA) complaint investigations declined slightly in 2005 from fiscal year 2004. Moreover, the number of violation cases declined by ten percent from fiscal year 2004. In fiscal year 2005, the government collected just over \$1.8 million in back wages for FMLA violations. Termination of employees seeking FMLA leave continues to be the primary reason that employees filed complaints.

Congress enacted FMLA with the idea of providing job-protected leave for an employee's or a family member's health condition that necessitated the employee's absence from work to care for him or herself or the family member. Although complaints about FMLA leave seem to have dropped, many employers allow great latitude granting questionable leaves with poor documentation — despite the fact that such leaves may cause severe work interruption. FMLA contains rules which safeguard employers by allowing them to require evidence of the basis for a leave request before authorizing time off. Many conscientious and compliance-minded employers worry about “provoking workers” if they require such evidence and consequently fail to insist on medical confirmation.

One employer reported a worker who regularly pulled into the parking lot on Friday mornings with his ski boat hooked to the back of a pickup truck, he would walk into the HR office to fill out the paperwork for FMLA leave then come back to work after a long weekend. This pattern continued throughout the summer!

One group, the FMLA Technical Corrections Coalition, is lobbying Congress to create a firm definition for “serious health condition” and to put limits on intermittent leave under FMLA. The DOL reports that 27 percent of FMLA leave is taken intermittently, which often creates morale problems for the employees remaining on the job.

Since You Asked: Creditable Coverage Confirmation

What happens if an individual is unable to produce a certificate of creditable coverage because his or her employer has gone out of business?

HIPAA provide rules that outline how to process alternative documentation in lieu of a certificate of creditable coverage. If the accuracy of a certificate is contested or a certificate is unavailable when the individual needs it, the individual has the right to demonstrate creditable coverage (and waiting or affiliation

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periods) by presenting documents or other proof. For example, the individual may use other means to demonstrate creditable coverage when:

- An entity has failed to provide a certificate within the required time period;
- The individual has creditable coverage, but the entity may be exempt from the HIPAA requirement to provide a certificate of creditable coverage;
- The individual has an urgent medical condition that necessitates a determination before he or she can deliver a certificate to the plan; or
- The individual has lost his or her certificate of creditable coverage and cannot get another one.

Documents

In the absence of a certificate, the individual may establish creditable coverage by providing any of the following:

- An explanation of benefit claims (EOB or other correspondence) from a plan or issuer indicating coverage
- Pay receipts showing a payroll deduction for health coverage
- A health insurance identification card
- A certificate of coverage under a group health policy
- Records from medical care providers indicating coverage
- Any other relevant documents that provide evidence of periods of health coverage

The individual may also establish creditable coverage through means other than documents, such as a telephone call from the plan or provider to a third party verifying creditable coverage.

Consideration of evidence

The plan must take into account all information that is submitted to determine whether that individual has creditable coverage and is entitled to offset all or a portion of any pre-existing condition exclusion period. The plan is required to treat the individual as having furnished a certificate if:

- The individual attests to the period of creditable coverage;
- The individual also presents relevant corroborating evidence of some creditable coverage during the period; and
- The individual cooperates with the plan's efforts to verify the individual's coverage.

Cooperation includes providing, upon the plan's or issuer's request, a written authorization for the plan to request a certificate on the individual's behalf and cooperating to determine the validity of the evidence and dates of creditable coverage. The plan can refuse to credit coverage when the individual fails to cooperate with the plan's or issuer's efforts to verify coverage.

U.S. Benefit Office Locations

Anchorage, AK (907) 562-2266	Atlanta, GA (404) 224-5000	Austin, TX (800) 861-9851	Baltimore, MD (410) 527-1200
Birmingham, AL (205) 871-3871	Boise, ID (208) 340-0645	Boston, MA (617) 437-6900	Cary, NC (919) 459-3000
Charlotte, NC (704) 376-9161	Chicago, IL (312) 621-4700	Cincinnati, OH (513) 762-7661	Cleveland, OH (216) 861-9100
Columbus, OH (614) 766-8900	Dallas, TX (972) 385-9800	Denver, CO (303) 218-4020	Detroit, MI (248) 735-7580
Eugene, OR (541) 687-2222	Farmington, CT (860) 284-6137	Florham Park, NJ (973) 410-1022	Ft. Worth, TX (817) 335-2115
Grand Rapids, MI (616) 954-7829	Greenville, SC (864) 232-9999	Houston, TX (713) 625-1023	Jacksonville, FL (904) 355-4600
Knoxville, TN (865) 588-8101	Las Vegas, NV (702) 562-4335	Long Island, NY (516) 941-0260	Los Angeles, CA (213) 607-6300
Louisville, KY (502) 499-1891	Memphis, TN (901) 248-3100	Miami, FL (305) 373-8460	Milwaukee, WI (414) 271-9800
Minneapolis, MN (763) 302-7100	Mobile, AL (251) 433-0441	Mountain View, CA (650) 944-7000	Naples, FL (239) 514-2542
Nashville, TN (615) 872-3700	New Orleans, LA (504) 581-6151	New York, NY (212) 344-8888	Omaha, NE (402) 778-4851
Orlando, FL (407) 805-3005	Philadelphia, PA (610) 964-8700	Phoenix, AZ (602) 787-6000	Pittsburgh, PA (412) 586-1400
Portland, OR (503) 224-4155	Roswell, NM (505) 317-3397	St. Louis, MO (314) 721-8400	San Diego, CA (858) 678-2000
San Francisco, CA (415) 981-0600	San Juan, PR (787) 725-5880	Seattle, WA (206) 386-7400	Spokane, WA (206) 386-7400
Tampa, FL (813) 281-2095	Washington, DC (301) 530-5050	Wilmington, DE (302) 477-9640	

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