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Wellness Programs: GM Demonstrates Strong ROI

General Motors (GM), the world's largest automaker, recently demonstrated the dramatic cost reductions possible through a wellness-related health plan. GM managed to cut healthcare spending by implementing a wellness program that included not only employees, but retirees.

According to a recent article published in *Business Insurance*, GM rolled out a health reimbursement account (HRA) for retirees and linked it to a wellness program. The program featured a health risk assessment. The results of that assessment were then used to provide targeted wellness programs for retirees. GM found that every retiree who merely *took* the health risk assessment ended up saving the health plan an average of more than \$400 per year. When retirees also attended two or more wellness programs, the health plan saved almost \$600 per year per retiree.

Although relatively few companies currently offer wellness programs for retirees, the success at GM will likely draw great interest. (GM is an ideal company to showcase wellness programs because it has the resources to produce meaningful cost statistics in tracking the experience of nearly 60,000 participants.) At the beginning of 2007, a South Carolina utility company offered its retirees the same wellness/health improvement programs offered to active employees. The rationale was that retirees can cost just as much or more in healthcare coverage than active employees, and if they can be taught or encouraged to engage in healthier lifestyles, not only will they benefit personally, but the company's bottom line will benefit as well.

Wellness and Disease Management Survey
November 2006



Willis

The success General Motors has enjoyed is not limited to huge organizations or retirees. Based on findings from our annual *Willis EB Wellness Survey*, we have reported promising financial results from the early adopters of comprehensive wellness programs. These programs typically include comprehensive employee communications, biometric screening, and financial rewards to drive changes in behavior. The expected ROI is at least 3:1 in medical claims savings over a three-year period. The return is much higher when savings from disability, absenteeism and presenteeism are included. (Presenteeism refers to productivity losses that result when someone chooses to work despite illness.)

IRS Issues HSA Limits for 2008

The Internal Revenue Service (IRS) recently announced inflation-adjusted limits for 2008 for health savings accounts (HSAs). *Revenue Procedure 2007-36*, which describes the new limits, also includes an important change in the way high-deductible health plans interact with HSAs. The timing of the release is itself noteworthy. Historically, the IRS released revised limits for the coming year as late as November. Because employers and plan participants need

HSA information in advance to meaningfully prepare and strategize about plan design, Congress directed the IRS to publish the new HSA limits by June. Future HSA limit adjustment announcements can be expected at about this time of the year.

Liberating HSA Contributions from the HDHP Deductible

Late last year Congress enacted significant changes to the laws governing HSAs to help make them more attractive to employees. (See the *Willis Employee Benefits Alert*, Issue 91, for details.) A key change enabled eligible individuals to set aside larger amounts in their accounts.

Under the old HSA rules, annual contributions could not exceed either the annual deductible under the high-deductible health plan (HDHP) or, if less, the statutory limit. In most cases, HDHPs had deductibles well below the statutory limits. As a result, the amount that could be contributed to an HSA each year was typically smaller than the amount envisioned by the original HSA legislation. Congress stepped in to correct this result by removing the tie to the deductible under the HDHP. *IRS Revenue Procedure 2007-36* formally adopted this change.

What does this mean? For taxable years beginning after December 31, 2006, the maximum annual HSA contribution is indexed to the statutory amount – without reference to the deductible of the high-deductible health plan.

The following table lists HSA limits for 2007 and 2008.

	Calendar Year 2007		Calendar Year 2008	
	Self-only	Family	Self-only	Family
Annual Contribution Limit	\$2,850	\$5,650	\$2,900	\$5,800
HDHP Minimum Deductible	\$1,100	\$2,200	\$1,100	\$2,200
HDHP Out-of-Pocket Limit (includes deductibles, copayments and other amounts but not premiums)	\$5,500	\$11,000	\$5,600	\$11,200

Self-Inflicted Injury: Covered or Not?

Many self-funded plans exclude coverage for self-inflicted injuries. A self-inflicted injury is typically one that results from an attempted suicide or reckless behavior. An injury sustained during the commission of a felony, such as driving under the influence or while intoxicated, would also fall into this category. However, Department of Labor rules on coverage could render such exclusions unenforceable.

Under this exclusion, a group health plan may not deny benefits for treatment of any injury that results from a medical condition, whether mental or physical.

Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination rules include a provision prohibiting discrimination based on source of injury. Under this exclusion, a group health plan may not deny benefits for treatment of any injury that results from a medical condition, whether mental or physical. The issue of mental health comes into play because self-inflicted injuries are frequently linked to mental health conditions. If a plan sponsor chooses to leave that exclusion in the plan document, then the employer should know that the provision may not always be enforceable. At a minimum, applicable HIPAA rules would require a plan sponsor to examine the facts and circumstances of such a case and reasonably determine whether the self-inflicted injury resulted from a medical condition such as depression.

A plan can more confidently exclude coverage for injuries that do not result from a medical condition, such as injuries sustained in high-risk activities (skiing, bungee jumping, etc.). Interestingly, although the HIPAA rules prevent a plan from excluding someone from eligibility based on the fact that he or she pursues a high-risk activity, an injury resulting from the high-risk activity may be excluded.

Retirees' Health Needs Are Rising

The *Washington Post* recently cited a Fidelity Investments study which showed that retiree healthcare costs for individuals without

employer-sponsored insurance are continuing to rise. Fidelity estimates that for a 65-year-old couple total medical expenses during retirement will average \$215,000. This is a 7.5 percent increase over last year's estimate and a 34 percent increase since 2001, when Fidelity began conducting the annual study.

For men living an average of 82 years and women living an average of 85 years, Fidelity calculated the impact of Medicare premiums, copayments and deductible expenses in its estimates. Analysts noted that 50 percent of individuals' Social Security benefits will likely be consumed by healthcare expenses for those with preretirement incomes of \$60,000. Health savings accounts (HSAs) may offset some of this burden, although a recent expansion of retiree contribution limits for these accounts could be repealed.



2006: Big Growth Year for Health Savings Accounts

To use a tax-favored health savings account, an individual must, among other things, have high-deductible health plan coverage that meets certain conditions. If growth in the number of people with such HDHP coverage indicates a growth in HSAs, then HSAs became much more widely used in 2006 than in previous years.

America's Health Insurance Plans (AHIP) recently reported a 43 percent increase during 2006 in the number of people with HDHP coverage. By AHIP's count, 4.5 million individuals now have HDHP coverage, compared to 3.2 million in January 2006 and one million in March 2005. (HSAs first became available January 1, 2004.) The number of individuals with HDHP

coverage does not directly correspond to the number of HSAs because many individuals who have HDHP coverage are dependents who are not eligible to open HSAs.

Although AHIP did not report the number of HSAs established by the 4.5 million individuals who have HDHP coverage, it did report on the characteristics of more than 350,000 HSAs owned by individuals who had HDHP coverage during 2006.

- Of the HSAs that were in place in 2006, 88 percent had average annual balances of \$2,500 or less, while four percent had average annual balances over \$5,000.
- As of January 2007, 65 percent of HSAs had been in place for less than one year.

Changes in Pension Accounting

After years of declining interest rates, cash crunches and demographic shifts that pummeled many pensions into severe states of under-funding, regulatory change is afoot. Accounting standards governing pensions are receiving much-needed reform with an eye towards promoting transparency, the *Journal of Accountancy* reported recently. The Financial Accounting Standards Board (FASB) has developed Statement No. 158, "Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans."

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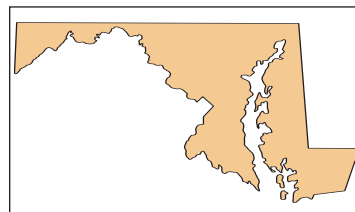
The new rules require organizations to transfer off-balance-sheet items onto company balance sheets. Although plan gains and losses were previously reported on company income statements, the accumulated values were not reported on company balance sheets. This change will more clearly reveal accumulated actuarial gains and changes to previous service expenses. The FASB also requires that companies now divulge the type and extent of changes in benefit obligations and plan

assets – including amounts that were deferred and recognized in other income. Employers can choose to report additional information that could be helpful for financial analysts.

The provisions are intended to enhance access to – and clarify – pension-related information. To that end, the new stipulations apply to post-retirement benefits in addition to pensions. The FASB is also initiating a broader review of pension accounting to determine if there are other areas that may be in need of reform.

A Win for Wal-Mart

The ride is over for a 2006 Maryland law requiring large employers to pay a percentage of their payroll to a Medicaid-related fund or offer healthcare benefits to



workers. Maryland Attorney General Douglas Gansler said that the state would not pursue further legal action to appeal several federal court rulings rejecting the law. The decision is a victory for Wal-Mart, which would have been the only employer in the state affected by the legislation. The attorney general finally acknowledged that while the law may not violate Maryland statutes, its provisions were preempted by federal health benefits laws (specifically, the Employee Retirement Income Security Act (ERISA)).

For additional information and background on Maryland's controversial law, please see the *Willis Employee Benefits Alert*, Issue 74.

Massachusetts Connector Releases Regulations

The Commonwealth Health Insurance Connector Authority (CHICA) has released final regulations for Section 125 Cafeteria Plan requirements and regulations for minimum creditable coverage (MCC) standards. The goal of the Section 125 Cafeteria Plan requirement is to make the state mandate to provide healthcare more affordable by giving employees the ability to purchase coverage on a pre-tax basis. The MCC

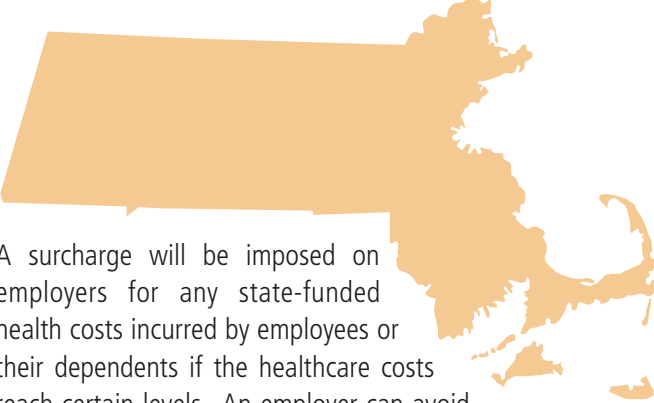
standards set forth the criteria for the minimum type of coverage an individual must have in order to avoid certain tax penalties.

The goal of the Section 125 Cafeteria Plan requirement is to make the state mandate to provide healthcare more affordable by giving employees the ability to purchase coverage on a pre-tax basis.

CHICA delayed the date by which Massachusetts' residents must have coverage that meets the MCC requirements. Although all residents must still have some sort of coverage by July 1, 2007, they now have until January 1, 2009 to acquire coverage that satisfies the MCC standards.

Section 125 Plan Requirements

The Massachusetts Health Care Reform Act requires employers with 11 or more employees in Massachusetts to establish and maintain a cafeteria plan in accordance with the rules set forth by CHICA as well as Section 125 of the Internal Revenue Code. The law is intended to give individuals the ability to pay health insurance premiums on a pre-tax basis; it does not require that employers contribute to the cost of health insurance premiums. The regulations are slated to go into effect July 1, 2007.



A surcharge will be imposed on employers for any state-funded health costs incurred by employees or their dependents if the healthcare costs reach certain levels. An employer can avoid this surcharge by offering employees the right to buy insurance on a pre-tax basis under a Section 125 cafeteria plan.

Under CHICA's Section 125 rules, cafeteria plan offerings must at a minimum include a premium-only option and offer access to at least one medical care coverage option in place of wages. The

medical care options can be individual policies or one of the plans provided through CHICA. (Employers, however, should note the difficult and complicated compliance issues that can surface if individual health insurance is paid for inside a cafeteria plan.) An employer who pays 100 percent of the cost of coverage for all of its employees (who are not otherwise excludable) and any dependent coverage to the extent elected by the employee is exempt from the rules.

An eligibility waiting period is permissible. While it can be structured to correspond to the waiting period for enrollment in the available medical care coverage options, the waiting period for the Section 125 plan cannot be in excess of two months for those employees for whom the employer makes no contribution. For those employees for whom the employer does make contributions, the eligibility waiting period can correspond to (but not exceed) the waiting period for the underlying medical options available to the employee. Eligible employees must be offered the right to elect to participate in the plan during any of the plan's applicable election periods, regardless of whether the employee was previously eligible or had previously waived participation in the plan during any prior election periods.

Certain classes of employees can be excluded from eligibility. These include:

- Employees who are less than 18 years old
- Temporary employees
- Part-time employees working, on average, less than 64 hours per month
- Employees who are considered wait staff, service employees or service bartenders, and who earn, on average, less than \$400 per month
- Student employees who are employed as interns or cooperative education student workers
- Seasonal employees who are international workers with certain types of visas
- Employees whose employer is required to contribute to a multiemployer health benefit plan

Employers will need to file a copy of the Section 125 plan with CHICA and designate an individual who will be authorized to verify and certify the accuracy of the submitted documentation. The plan document can be a separate, stand-alone document or combined

with other employer-provided plans. The employer can utilize more than one Section 125 Cafeteria plan document to provide employees with access to medical care options, including establishing a plan only for those employees not eligible for the employer's subsidized healthcare options. The plan's effective date must be no later than the date on which the employer becomes subject to the Section 125 Cafeteria plan requirement. The law does not intend its rules to be inconsistent with the rules of the Internal Revenue Code, and it will not require any employer to act in any way that violates the IRS's Section 125 rules.

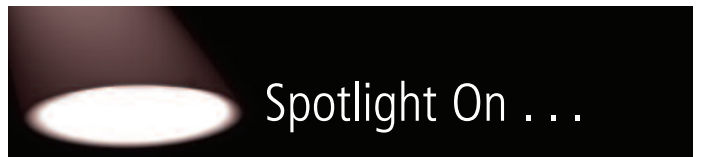
MCC Standards

Beginning July 1, 2007, taxpayers in Massachusetts will be required to have health insurance. Although CHICA has mandated certain minimum requirements for coverage, enforcement of these requirements has been delayed. This means that any type of health coverage that the taxpayer has will satisfy the requirements. No tax exemptions will be lost and no tax penalties will be assessed. Effective January 1, 2009, though, the coverage must satisfy a variety of requirements in order for the individual to avoid applicable tax penalties. Specific details about MCC coverage requirements are available from your Willis representative.

Conclusion

Does ERISA preempt the Massachusetts requirement for employers to sponsor a Section 125 plan? Although a Section 125 plan is not directly subject to ERISA, we believe there are strong legal arguments supporting the position that such a mandate is preempted. Few employers, however, are likely interested in presenting a test case on this question. Consequently, we anticipate most employers will voluntarily comply and wait until the courts resolve the many legal issues stemming from this controversial and high-profile Massachusetts law.

The compliance deadline for the Massachusetts Health Care Reform Act is quickly approaching. Although the release of the regulations discussed above is welcome, many questions still remain. This is particularly true for the Section 125 Cafeteria Plan requirements. CHICA has information on its web site about the law that employers may find helpful. This includes an employer handbook and frequently asked questions that might be posed by individuals, employers and brokers (<http://www.mass.gov/?pageID=hichomepage&L=1&L0=Home&sid=Qhic>).



The Plan Amendment Process

We are often asked about the proper way to amend an employer's benefit plan document. In many cases, the answer lies in the document itself – and so it should. A well crafted plan document should not only describe exactly what the plan sponsor envisions, it should also include a formal and clear amendment process. Following this process is crucial for the amendment to be successfully implemented.



One common problem in amending a plan is determining who has authority to amend it. The board of directors of a corporation will have authority in virtually all cases to amend the corporation's benefit plans, even if not otherwise stated in the plan. In most other situations, it is wise to make sure the person signing off on the plan amendment has the authority to do so. The vice president of Human Resources may be empowered to sign a plan amendment while the office manager at a remote work site will likely lack that authority.

Even seemingly inconsequential plan changes will probably not be considered legally effective if they do not comply with the formal procedure for adoption specified in the plan. In one relevant court case, a plan sponsor announced at an employee meeting and also posted a notice on an employee

bulletin board that the plan would not cover motorcycle accidents. When a participant was later injured riding a motorcycle, the plan was held liable for the accident expenses because the oral announcement and informal bulletin board notice did not fulfill the formal amendment policy requirement. (Readers should note that not all courts agree on this point. As is often the case, local facts and circumstances can be decisive.)

To avoid unnecessary delays and lag time when minor plan corrections are needed, the board of directors (or other governing body) of a plan sponsor can simply delegate to a corporate officer the authority to act on behalf of the plan sponsor to make plan changes. Care should be taken to ensure the delegation is consistent with governing business law and company documents, and that the delegation is properly evidenced in writing. The person operating under this delegated power must also be careful to act within the scope of the delegation and to document all actions.

It is also important to recognize ERISA reporting and disclosure obligations by determining whether a proposed amendment would change any of the elements of the plan that must be disclosed in the summary plan description. If so, the plan amendment would trigger the requirement that a summary of material modification (SMM) be provided to employees. SMMs must generally be distributed within 210 days of the close of the plan year in which the amendment is adopted. However, if the proposed amendment represents a cutback in health plan benefits, then not only is an SMM triggered, but a special ERISA rule requires that the SMM be distributed within 60 days of the date the plan modification is adopted.

Any amendment activity is predicated on the plan's being legally subject to change. Language to that effect should always be included in all plan documents, or an employer faces the possibility that its plan cannot be amended at all with respect to current participants. Perhaps the lesson here is simple: keep a copy of your plan document somewhere you can easily find it – and read it.

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