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Supplemental Wellness Programs: DOL to Weigh In

Smokers can breathe easy – or at least easier. The Department of Labor (DOL) is reportedly on the verge of closing a regulatory loophole that has reportedly been used to penalize employees for failing to meet wellness requirements, e.g., for smoking. Regulations under the Health Insurance Portability and Accountability Act (HIPAA) prohibit any discriminatory action based on health status, but some vendors have exploited a loophole whereby supplementary benefits plans are not subject to HIPAA rules. In several cases, these vendors offer a high (potentially very high) deductible plan under HIPAA rules and a supplementary plan that offers to pay much or all of the deductible. The supplementary plan, free of HIPAA restrictions, is only available to those meeting a set of wellness requirements. Beyond the smoking issue, employees may be required to have a body mass index (BMI) under 31 and cholesterol levels under 200. The result is that employees failing to meet the employer's health measures are financially penalized. Employers that want to promote healthier lifestyle behavior often seek to implement programs with penalties severe enough to alter participant behavior. These efforts may prove more difficult under updated DOL health status safeguard requirements.

According to our research, the DOL is preparing new guidance that will clarify how the supplemental plan exception should be applied. Few details are available as the DOL clearance process progresses, but the DOL is expected to reject these arrangements as impermissible methods of sidestepping the wellness regulations. No definitive publication date has been announced, but the department is reportedly moving with unusual speed to head off vendors seeking to market these programs. The new guidance is expected before the end of the year.

Willis recently considered this issue in depth in the recent *Employee Benefits Alert, Issue 113, "Wellness Incentive Restrictions – Is There Really a Loophole?"* We concluded that employers should use extreme caution when considering such plans. The latest reports underscore this advice.

IRS: Additional Time to Prepare NQ Deferred Compensation Plan Documents

The IRS has extended transition relief for employers who are working to comply with rules governing nonqualified deferred compensation plans. Employers will be allowed to make certain temporary changes to their plans that might otherwise violate the rules. Last spring the IRS issued final regulations on the topic under Section 409A of the Internal Revenue Code, including a transition relief period through the end of 2007. The recent IRS notice extends the period through the end of 2008.



Employee benefits practitioners have struggled with Section 409A rules, particularly in regard to deferral elections, timing of payments and documentation, since the rules first went into effect January 1, 2005. Compliance is complex, usually requiring investigation and coordination of the interactions among various nonqualified deferred compensation plans, employment agreements and other arrangements. The transition relief was granted in response to practitioners' pleas for additional time to comply. It is limited to a few troublesome areas, however, and is unlikely to be extended again. The IRS was careful to state in its recent announcement that the final regulations will still become

effective on January 1, 2008, and that nonqualified deferred compensation plans must comply with many of the operational provisions in the final rules by then.

Washington Update: Mental Health Parity

The mental health lobby marked two recent victories in the fight for mental health parity. Congress introduced two bills that press forward on this contentious issue. Even though mental health parity mandates have been around for a decade, the mental health community remains largely dissatisfied with the way employer mental health benefits are paid.

Both houses of Congress have acted, with the Senate approving the Mental Health Parity Act of 2007, S. 558, and the House Committee on Ways and Means approving the Paul Wellstone Mental Health and Addiction Equity Act of 2007, H.R. 1424. There are substantial differences between the bills.

The Senate bill would require group medical plans to apply no more stringent financial restrictions on mental health treatments than they do on other medical treatments with respect to deductibles, co-payments, out-of-pocket expenses, coinsurance, covered hospital days and covered outpatient visits. This represents an expansion of the current parity requirements.

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The House bill goes further, mandating that employer plans provide the broad mental health coverage currently available to members of Congress. Employers and health plans would have to cover all mental health conditions and substance abuse disorders in the DSM-IV manual – if a plan covers any mental

health conditions at all. (DSM-IV is the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.) In addition, the bill would broadly expand the ability of states to legislate in this area by specifically authorizing states to enact laws offering greater levels of mental health parity protection than available under federal law. Some experts have expressed concern that the anticipated higher health plan costs associated with the House version of the bill might cause some plan sponsors to reconsider their benefit programs.

The House version of the proposal goes well beyond parity and requires much more extensive coverage than many plans currently offer. Willis is working with our colleagues on the American Benefits Council to support the Senate version of the bill. The Bush administration has indicated that it does support parity as a general principle. Some legislative observers believe the president also leans towards signing the Senate bill.

State Children's Health Insurance Program (SCHIP)

President Bush vetoed SCHIP legislation recently passed by Congress, but the program has wide bipartisan support, and another SCHIP bill will likely be submitted. Some political commentators have suggested that the Democrats may hold back the SCHIP extension for political reasons, but we think this is still a timely moment to examine some of the provisions that have garnered attention during the legislative process.



The final bill contained a mandate that employers report to state governments detailed information about their plan provisions. States would use this information to determine whether it would be less expensive for the state to pay for the employer-provided coverage or to directly provide coverage under a state plan. This potential reporting obligation (in all 50 states) is particularly objectionable to many employers. The mandate would also require employers to notify employees about the availability of state assistance for eligible individuals.

The House bill included a mandate for employer plans to pay for end-stage renal disease (ESRD) for up to 42 months, plus waiting period (an increase from the current 30 months, plus waiting period) before Medicare becomes primary. That provision was not included in the version of the bill that was passed and sent to the president. However, it is an indication of the type of specific and potentially expensive new mandates that the House of Representatives is considering.

These provisions may or may not be in the next SCHIP bill, but benefits professionals will want to keep an eye out for these and other details.

Healthcare Reform Moves Forward in California

Healthcare reform in California appears to be on the way, although its ultimate form is uncertain. Governor Arnold Schwarzenegger (R) officially presented a healthcare reform bill that updates a proposal he outlined in January 2007. The Health Care Security and Cost Reduction Act would require all Californians to have health insurance coverage. Initially, the governor proposed that costs of the program be shared among doctors, hospitals and employers who do not offer healthcare coverage to employees. Under the governor's new plan, doctors would no longer be required to contribute and employer contributions would be based upon a sliding scale: from zero to four percent of total payroll. Employers with payrolls under \$100,000 would not have to contribute. Originally, a contribution of four percent of payroll was required from employers with 10 or more employees. Additional financing for the \$14 billion dollar plan would come from leasing the state lottery to a private firm. A side-by-side comparison of key points in the governor's January proposal and the Health Care Security and Cost Reduction Act is available on the office of the [governor's web site](#).

A competing healthcare reform bill has already made its way through the California legislature. The bill, AB 8, does not include an individual insurance mandate, and funding would come from an employer assessment of 7.5 percent of payroll. Maryland passed a similar law in 2006, but the courts struck it down on the grounds that it was preempted by the Employee Retirement Income Security Act (ERISA). (See *Willis' Employee Benefits Alert, Issue 74, "Federal Court Overturns Maryland's 'Wal-Mart' Health Care Law."*) Governor Schwarzenegger has stated that he will veto AB 8, arguing that it is "financially unsustainable" because the financial burden rests entirely on employers.

As we prepared this article, Governor Schwarzenegger called the legislature into a special session to work on enacting comprehensive healthcare reform by the end of the year. Benefits professionals across the nation will be watching.



In related news, the hearing date for the Golden Gate Restaurant Association (GGRA) lawsuit against the city of San Francisco's Health Care Security Ordinance has been delayed until November. This delay makes it unlikely that a decision in the case will be reached before the ordinance's January 1, 2008 effective date. This means that the GGRA will need to obtain an injunction if it wants to stop the law from going into effect. For more information about the law mandating employer contributions to employee healthcare, please see *Willis' Employee Benefits Alert, Issue 112, "San Francisco Delays Health Care Security Ordinance Effective Date."*

Comparing US and European Healthcare Costs

Healthcare costs are higher in the US than in Europe, due, at least in part, to obesity. According to a new study reported by Reuters, ("Obesity may push U.S. health costs above Europe: study," published on the Reuters web site October 2, 2007) obesity rates in the US are nearly twice what they are in

Europe. About 33 percent of Americans are obese, compared with 17 percent in 10 of the European countries sampled for the study. Obesity is often cited as a key factor in Americans suffering a greater incidence of cancer, diabetes and other serious disorders. Treatment of these and other chronic diseases is estimated to add more than \$100 billion to total US healthcare expenditures. Tobacco usage is another key factor in many chronic illnesses. Although Europe is often noted for a greater tolerance of smoking, over half of Americans are former or current smokers, compared with about 43 percent in the study's European sample.

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HIPAA Goes Hollywood

A little celebrity excitement does not excuse HIPAA violations. This lesson was learned by some star-struck staff members at a New Jersey hospital who peeked at the medical records of actor George Clooney after he and a female companion wound up at the facility following a motorcycle accident. Initial reports said that as many as 40 staffers, including doctors, at Palisades Medical Center in North Bergen looked at Clooney's medical

records and may have provided information to the media. After an internal hospital investigation, 27 employees were suspended for a month without pay and may still face further disciplinary action, according to a hospital spokesperson.



When a HIPAA breach occurs, one of the key obligations for a covered entity is to mitigate damage and take immediate steps to demonstrate meaningful corrective action to prevent the problem from recurring. Luckily for the hospital, it appears that the actor won't pursue the HIPAA violation with a complaint to the Department of Health and Human Services (DHHS) – but he certainly would have every right to do so. The violation appears to be a HIPAA version of a *Perfect Storm*, although it also seems to fall short of *Intolerable Cruelty*.

Prescription Drug Inflation Slowing

The annual inflation rate for drug costs is at its lowest level in three decades, according to several reports. Department of Labor statistics showed that the rate of increase over the last 12 months was one percent.

As recently as 2005, inflation in drug prices was running at an annual rate of 4.4 percent. Some experts attribute the

slowdown to a surge in the number of people using generic medications and the fact that generic versions of some of the most common drugs have recently come on the market. The article reports that new generic equivalents of popular drugs such as *Zocor* for cholesterol treatment, the sleeping pill *Ambien*, and the blood pressure drug *Norvasc* have become available in the last 18 months.

According to the nonprofit Kaiser Family Foundation, the average brand-name prescription cost more than three times the average generic in 2006. Generics made up 63 percent of prescriptions dispensed in the US in 2006, up 13 percent from 2005.

Other experts credit Wal-Mart for the slowdown in drug costs, citing Wal-Mart's decision to offer many generic prescriptions at \$4 for a 30-day supply. Target and Kmart immediately responded with low-cost generic programs. Other retailers and even regional grocery store chains followed with their own low-cost prescription drug programs. Although Wal-Mart's list of discounted generics started with about 350 drugs, the company recently announced that next year, 2,400 generics would be available to its employees at \$4 a month. The company has also suggested that it may expand its generic drug program correspondingly for consumers.



The government still expects long-term drug spending to surge. Projections suggest annual costs will near \$500 billion in 10 years, up from an estimated \$275 billion this year. The trend may be irreversible because the population is aging, individuals continue to take more medications and new drugs are continually introduced in the marketplace. Also, costs are expected to soar in some specialized categories like cancer treatments and biotechnology drugs.



Spotlight On . . .

Discount Health Plans?

Discount health plans are often advertised on late-night TV, in newspapers, via faxes and through internet spam. These plans often tout lower costs than what some workers may be paying for their employer's group health coverage. The temptation is obvious, but buyers should beware. This is not an apples-to-apples comparison. Discount health plans are not directly comparable to health insurance plans, and price should not be the only criterion used in choosing between them. Buyers should understand what discount health plans are and the ramifications of dropping active group health coverage to obtain discount health coverage.

What Are Discount Health Plans?

Discount healthcare plans are not insurance at all. As their name implies, they offer lower cost medical services from hospitals and doctors. Discount health plans usually charge a membership fee in exchange for a list of healthcare providers who will provide services at a discounted rate to its members.

Because discount health plans are not considered health insurance, in most cases they are not regulated by a state's department of insurance. If a consumer grew dissatisfied with a discount health plan, the consumer protections available to purchasers of health insurance regulated by the state generally would not be available. Anyone who might be thinking about a switch to a discount plan should call their state's department of insurance to ask whether the program is offered by a licensed insurer. The odds are, it is not.

As reports of disreputable discount health plans emerge, a growing number of states are beginning to prosecute fly-by-night operators who peddle overstated health coverage benefits to the uninsured. To file a complaint about a discount plan, visit your state department of consumer affairs or the Federal Trade Commission. The FTC may be reached toll free at 1 877 382 4357 or through its [web site](#).

Here are points for buyers to consider in evaluating the discount health plan option.

- If someone drops bona fide health insurance after buying a discount health plan and then later decides to buy bona fide health insurance again, the new health insurance may not cover pre-existing conditions. This is because discount coverage is not considered creditable and therefore will not protect against a person experiencing a 63-day break in coverage. For more information about HIPAA's break in coverage rule, please see the February 2005 issue of *FOCUS on Benefits* and Chapter Nine of the *Willis On-Line Compliance Manual*.
- Purchasers of discount health coverage should read their plan information carefully to determine if it provides the services advertised.
- Seniors should be especially cautious when considering discount coverage. Some providers may not honor discounts for Medicare-reimbursed services.
- Consumers evaluating discount coverage may wish to randomly contact participating providers in advance to make sure they will actually accept the discount that is advertised.
- Consumers should ask about the plan's cancellation and refund policy.
- Consumers should keep copies of all materials submitted to and received from the plan.
- One of the main features of many employer-provided health insurance plans is a maximum out-of-pocket ceiling. There is likely no ceiling on expenditures in a discount health plan.

Key Contacts

US Benefits Office Locations

Atlanta, GA
404 224 5000

Florham Park, NJ
973 410 1022

Naples, FL
239 659 4500

San Jose, CA
408 436 7000

Austin, TX
800 861 9851

Ft. Worth, TX
817 335 2115

Nashville, TN
615 872 3700

San Juan, PR
787 725 5880

Baltimore, MD
410 527 1200

Grand Rapids, MI
616 954 7829

New Orleans, LA
504 581 6151

Seattle, WA
206 386 7400

Birmingham, AL
205 871 3871

Greenville, SC
864 232 9999

New York, NY
212 915 5422

Tampa, FL
813 281 2095

Boston, MA
617 437 6900

Houston, TX
713 961 3800

Omaha, NE
402 391 1044

Washington, DC
301 530 5050

Cary, NC
919 459 3000

Jacksonville, FL
904 355 4600

Orange County, CA
949 885 1200

Wilmington, DE
302 477 9640

Charlotte, NC
704 376 9161

Knoxville, TN
865 588 8101

Orlando, FL
407 805 3005

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Chicago, IL
312 621 4700

Las Vegas, NV
702 432 7100

Philadelphia, PA
610 964 8700

Cincinnati, OH
513 762 7855

Long Island, NY
516 941 0260

Phoenix, AZ
602 787 6000

Cleveland, OH
216 861 9100

Los Angeles, CA
213 607 6300

Pittsburgh, PA
412 586 1400

Columbus, OH
614 766 8900

Memphis, TN
901 248 3100

Portland, OR
503 224 4155

Dallas, TX
972 385 9800

Miami, FL
305 373 8460

Roswell, NM
505 317 3397

Denver, CO
303 218 4020

Milwaukee, WI
414 271 9800

St. Louis, MO
314 721 8400

Detroit, MI
248 735 7580

Minneapolis, MN
763 302 7100

San Diego, CA
858 678 2000

Farmington, CT
860 284 6147

Mobile, AL
251 433 0441

San Francisco, CA
415 981 0600