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### **Congress Caps Deferred Comp?**

As part of its new minimum wage proposal, some members of Congress hope to simultaneously provide a tax cut for small business. However, because of a House pay-as-you-go rule, new tax cuts must come with a corresponding revenue producer in the legislation. As a result, the Senate has been considering a plan to take dollars from highly paid executives to help balance the tax cut. (Although at press time it appeared that the Senate would ultimately reject the move to tax highly paid executives, members of the House still seem determined to pursue the plan.)

Under the controversial tax measure, proposed minimum wage legislation would limit annual nonqualified deferred compensation to the lesser of \$1 million or the individual's compensation averaged over five years. All amounts over that are deferred under all plans are subject to ordinary income tax plus the 20 percent additional tax on amounts deferred in 2007 and later (including earnings).

The bill would also amend the section 162(m) provision that generally limits employer deductions for the compensation of certain employees (CEO and top four most highly compensated officers). Once an employee is covered by section 162(m) the employee would continue to be covered by section 162(m) forever — even if the individual no longer satisfies the “top-paid executive” definition.

Many economists would call this a misuse of the tax code, and specifically section 162(m). Such actions led directly to the explosion of compensation in the form of stock options (which were not subject to the 161(m) limits). Congress inadvertently spurred interest in stock options as an executive compensation tool.

This reliance on stock options magnified the perception of uncontrollable executive pay practices. With a Democratic Congress, there is renewed determination to tax highly paid executives. If the adage “history repeats itself” proves true, this new legislation will only lead to an innovative way to further compensate executives and make this “balancing act” a moot issue.

## **FMLA: Persistent Employer Pain**

The *Family and Medical Leave Act of 1993* (FMLA) aimed to protect a person from losing their job while on leave to care for the employee's or a family member's health conditions.

Although many workers are grateful for FMLA leave, worker absence has been building employer resentment. Complaints about FMLA leave have increased over the years. Although the number of DOL initiated FMLA investigations declined slightly in 2005 from fiscal year 2004, employers continue to struggle with implementation. Afraid of denying leave that may qualify, many are granting questionable FMLA leaves resulting in severe work interruption. This is in spite of FMLA rules that safeguard employers by allowing them to require documentation for a leave request before authorizing time off. Unfortunately, some employers worry about provoking workers if they require such evidence.

One group, the FMLA Technical Corrections Coalition, is pushing Congress to create a firm definition for "serious health condition" and to put limits on intermittent leave under FMLA. For many employers intermittent leave is the most difficult to manage. The DOL reports that 27 percent of FMLA leave is taken intermittently — often creating morale problems for the employees remaining on the job.

According to the publication, the *National Law Journal*, the Department of Labor has launched an investigation into the proper use of the FMLA. Some employment attorneys claim that growing numbers of workers are asserting that firms are unfairly denying them leave under the act, while many employers contend that workers abuse FMLA provisions. Some individuals also allege that companies are retaliating against them for filing complaints or seeking time off under the act. Attorneys agree that both sides continue to argue over whether stress-related illnesses are covered. Court rulings have only added to the confusion, particularly over the use of intermittent leave — which can leave companies with difficult to overcome operational weaknesses.

As the DOL investigates the law's effectiveness, employers are hopeful. Worker advocacy groups, however, are concerned that the department will use the inquiry as an excuse to erode FMLA privileges. In the meantime, many companies are instituting new procedures to more tightly manage FMLA usage, requiring second and third opinions for FMLA requests or declaring workers unqualified for the benefit.

## **On-Site Health Clinics: Cost Cutting Tool?**

The *New York Times* recently published an article about a resurgence in the appeal of on-site, employer-provided medical clinics. Apparently driven by runaway health costs, the *Times* indicates that some large employers are moving to establish primary care medical centers in their offices and factories as a way to offer convenient service and free or low-cost health care to their employees. Within the last two years, companies including Pepsi, Sprint, Florida Power & Light, Credit Suisse and Toyota have opened or expanded on-site clinics. Other employers are adding or planning to add even more clinics — which were experimented with during the 1970s but fell out of favor amid questions about their cost-effectiveness. More than 100 of the nation's 1,000 largest employers now offer on-site primary care or preventive health services — a number forecast by some to exceed 250 by the end of the year.

The logo for Willis, featuring the word "Willis" in a large, blue, serif font.

The new look found at many in-house medical offices goes well beyond simple occupational health clinics that traditional factories have long maintained for job-related injuries and worker's compensation cases. In many cases, employees can now stop by for check-ups, allergy and flu shots, pregnancy tests or routine monitoring for chronic diseases like diabetes and asthma.

The article notes that as health insurance premiums have soared and many companies have run up big bills at emergency rooms and urgent care centers — the corporate clinic offers an effective cost control option. For employees, on-site clinics can mean faster medical attention and lower out-of-pocket costs, because visits are usually free or require a small co-payment.

Although not entirely without sometimes difficult compliance challenges, on-site clinics can mean gains in productivity and lower health-insurance outlays. The *Times* quotes one health care specialist as saying, "A clinic serving a couple thousand employees can probably save \$1.5 million to \$2 million a year."

### **Stronger Oversight of 401(k)s**

The Government Accountability Office (GAO) recently concluded that employees get information about their plan's expenses in a "piecemeal" fashion, and that regulators need more details about those charges to conduct effective oversight. The Labor Department has responded by working on rules to make fees and commissions related to 401(k) plans more transparent to workers. The department's initiatives are in different stages of development, but proposals to improve plan expense reporting are expected in the spring. In a related move, Congress is considering legislation to protect workers from unreasonable fees and commissions.

The *Los Angeles Times* reports that while employers are required to ensure that fees and commissions paid to brokerage firms are reasonable, information about the fees is often difficult to uncover. Moreover, the GAO recently reported that a majority of employers reflexively pass these fees onto workers — rather than take steps to reduce the fees. Fees are generated not only for each investment, but for recordkeeping costs and other administrative concerns. Also troubling, the Investment Company Institute reports that about two-thirds of plan participants do not review their prospectuses, which is the primary method plans use to inform their participants about fees and the like.

As many companies have backed away from traditional pensions, 401(k) plans have spread rapidly, and they now cover over 45 million Americans — more than double the number in conventional plans. Congress and government regulators are planning an array of moves to improve oversight of 401(k) accounts on which millions of Americans rely, but which are also often burdened by hidden fees that chip away at their value.

### **Does Medicare Bonus Improve Quality?**

The *New York Times* reports that of the 266 hospitals taking part in a three-year Medicare experiment that aims to boost quality of care, 115 will share a total of \$8.7 million in performance bonuses for the second year of the program. Hospitals are assessed using 30 quality



measures, with a focus on joint replacement, coronary artery bypass graft, heart attack, heart failure, pneumonia, and whether medical recommendations are being followed in these treatment areas.

Hospital officials believe that any Medicare pay-for-performance program should concentrate on the delivery of better care and patient outcomes, rather than linking bonuses to certain treatments. Nevertheless, the article notes that most observers believe that, since its inception the program has demonstrated meaningful success in lowering heart-attack-related deaths and getting hospitals to share information.

### **Update: Massachusetts Health Care Reform Act**

The committee under the Commonwealth Health Insurance Connector Board (CHICB) is responsible for determining the minimum standards for the insurance that Massachusetts residents will be required to purchase in order to comply with the law. CHICB's proposed guidelines for minimum coverage include:

- A limit on out-of-pocket costs for covered medical services,
- A limit on permissible annual deductibles,
- Coverage of a limited number of routine physician office visits per year (before satisfying the annual deductible), and
- Coverage of prescription drugs after the deductible is satisfied.

The draft guidelines can be found at: <http://www.mass.gov/Qhic/docs/Policy%20Committee%20Recommendations%20on%20Minimum%20Creditable%20Coverage.doc>

Final recommendations are being delayed until cost questions can be answered. When the legislation was first proposed, former Governor Mitt Romney (R) projected that monthly premiums would be about \$200. Initial bids submitted by responding insurers indicate that the average monthly premium for a mid-range individual policy is \$380.

The Division of Health Care Finance and Policy plans to hold new hearings and reissue the regulations prior to the July 1, 2007 effective date.

### **COBRA — No Free Rides**

COBRA failures represent such a highly sensitive issue for employers that many organizations automatically choose to offer COBRA even if it would not be technically required under the particular circumstances. The following case may be helpful, and reassuring, to anxious plan sponsors.

In the case of *Jordan v. Tyson Foods, Inc.*, M.D. Tenn., No. 3:05-0513 (November 2, 2006), Jason Jordan sued Tyson Foods alleging COBRA violations. Jordan had worked for IBP, Inc. since April of 2001 and participated in their group health plan.



In September 2002, Tyson Foods purchased IBP. In the process of merging the two companies, Tyson announced that IBP employees, then covered under the IBP plan, would be allowed to elect coverage under the Tyson Foods Employee Welfare Plan — as long as those elections were completed by October 1, 2002. Tyson also stated that any employee whose premium payments lapsed under IBP's plan would *not* be eligible to enroll in Tyson's benefits.

Mr. Jordan began a medical leave in June 2002 and was scheduled to be absent from work until January 6, 2003. His medical leave started before the IBP acquisition by Tyson Foods and, at some point during the leave, Jordan's IBP coverage lapsed due to non-payment of premium. Then, Jordan did not report back to work on January 6, 2003. When he did not respond to a request for medical documentation, his employment was terminated on January 31, 2003.

Although some of the facts were omitted from the published opinion, we are left to presume that FMLA was not at issue. This issue of FMLA is important because an employee who does not return to work at the expiration of his FMLA leave will generally experience a COBRA qualifying event at the end of FMLA.

Because Jordan had failed to pay his group health insurance premiums under the IBP plan, Tyson Foods did not offer him the opportunity to enroll under its medical plan. On March 21, 2003, Jordan's attorney sent a letter to Tyson saying that Jordan was electing COBRA coverage under the Tyson Foods Employee Welfare Plan (although Tyson had not offered Jordan COBRA coverage). Jordan initiated legal action against Tyson Foods seeking to recover per-day statutory COBRA penalties (plus other damages totaling \$95,700) stemming from what Jordan alleged was Tyson Foods' failure to send a COBRA notice in a timely manner.

Jordan claimed that he experienced a COBRA qualifying event either at his termination from the IBP plan, or his termination of employment with Tyson.

*IBP: Did a qualifying event occur?*

With respect to the termination of his IBP coverage, the court noted that a lapse or termination of coverage because of nonpayment of premiums is not a qualifying event that would trigger the right to elect COBRA.

*Tyson Foods: Did a qualifying event occur?*

Next, the court examined whether or not Jordan was a participant under the Tyson Foods plan. Under the terms of the Tyson Foods plan, the only individuals who were eligible to make elections under the Tyson Foods plan by October 1, 2002 were those employees who had coverage under the IBP plan. Because he allowed his payment to lapse, Jordan was never eligible for coverage under the Tyson plan. Jordan therefore had no basis to assert that a COBRA qualifying event occurred when he lost coverage under the Tyson Foods plan. In fact, he never had Tyson coverage and so, according to the court, he could not have lost it.

We are bewildered about why Jordan's attorneys thought that there was a legitimate issue on which to base their claims. Nonetheless, this case is a helpful reminder for group health plan sponsors. Carefully and reasonably consider the facts when making COBRA decisions and where the facts support withholding COBRA do not respond to pressure to inappropriately extend coverage.



## Beneficiary Will Sue Plan Fiduciary

A new federal court decision reminds employers about their fiduciary duties with respect to employee benefit plans they sponsor and offers an important lesson about the scope of ERISA's protective powers. *Deluca v. Blue Cross Blue Shield of Michigan* (E.D. Mich., No. 06-12552, January 25, 2007).

As fiduciaries under ERISA, employers are required to discharge their plan duties solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable plan administration expenses. Fiduciaries are directed to do this with the care, skill, prudence and diligence under the circumstances that a prudent person who is familiar with such matters would use. Although this case was brought against an insurance company, the fact that the case was permitted to proceed is an indication that employers should take their ERISA duties seriously.

### Background

Anthony Deluca joined the plan of his wife's employer, Flagstar Bank. One week later he was the lead plaintiff in a class action suit filed in a U.S. District Court alleging that Blue Cross Blue Shield (BCBS) of Michigan violated its fiduciary duty to the Flagstar Bank plan because BCBS negotiated "more favorable rates" for its HMO with area physicians and hospitals than the rates it negotiated for self-funded plans that it administered. The chief allegation was that BCBS actually promised the hospitals that it would offset the lower costs for the HMO with higher costs from the self-funded plans. (Thereby violating ERISA fiduciary duties to participants in the self-funded plans.)

### Discussion

The insurer sought to have the suit dismissed because it claimed that Deluca did not have the right to file the suit against the plan primarily because — even if everything he said was true — he had not been damaged as a result.

Deluca had only been a group health plan beneficiary for a single week and had not even filed a claim, much less had to pay more for his care because of the alleged deal between the hospitals and BCBS. This reasoning, however, was dismissed as irrelevant by the court. Because the case was filed on behalf of the plan, not on behalf of the individual, it did not matter that the plaintiff had not personally suffered any damages. Ultimately, the court did find that the individual had a right to sue the fiduciary to seek a recovery on behalf of the plan.

### Conclusion

It seems clear that this case was specifically brought by the plaintiff's attorneys to seek recovery of attorney's fees as permitted under ERISA. For one thing, it is unlikely that a complaint could be drafted and served so quickly after the beneficiary joined the plan — unless it had already been in the works for some time. Here is a case where the attorneys seemed to be hunting for a suitable plaintiff in order for them to file the lawsuit. It also illustrates the types of cases that could be lurking and simply waiting to be filed with respect to plans generally. Plan sponsors should make careful deliberation of any decision regarding ERISA programs to ensure that they are not violating their fiduciary duties.

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