HUMAN CAPITAL PRACTICE

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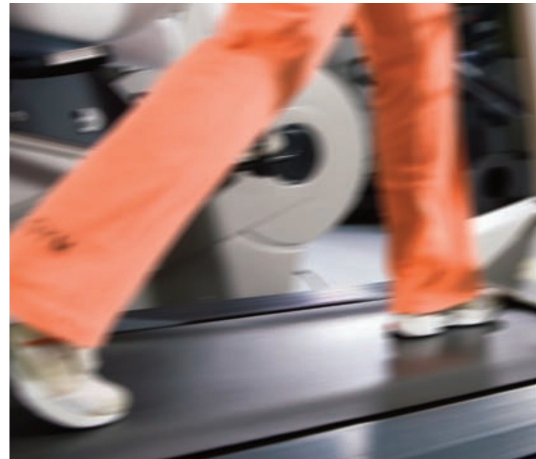
WELLNESS



WELLNESS PROGRAM + RIGHT VENDOR = HEALTHY START

More and more companies are seeking to control health care costs and improve employee health and productivity, so it is not surprising that interest in implementing wellness programs has grown exponentially over the past few years. Consequently, the wellness vendor industry has also blossomed.

Many employers are challenged with determining what type of programs and events will most effectively meet their program goals. Vendors must be reliable and deliver effective programs and tools. The wellness vendor can make or break a program, so selecting the right one for your organization is critical in creating a viable, sustainable program. When employees have a positive experience, they are more likely to engage in future program activities and share their positive experience with others. Conversely, when employees have a negative experience, participation can drop along with employee confidence and support of the wellness program in general.

Seeking vendors that deliver quality services, provide a professional, positive experience for employees and help drive results is not easy. Despite the growing numbers of wellness vendors, not many have long-term, proven program success. Below are some key areas your organization should consider in assessing potential wellness vendors.

PRODUCTS/SERVICES

Review and confirm the products and services the vendor provides. Request documentation of costs of products/services and comparative vendor data relative to their success rate.

QUALIFIED STAFF

Inquire about the education and training of the service delivery staff. Consider if the staff has appropriate certification and/or credentials for promotion of general health and specific to their roles.

MARKETING AND PROMOTION

Ensure that the vendor will provide marketing or promotional materials to help support the program. Some vendors will customize

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HR CORNER

BEWARE OF BIAS TOWARD CAREGIVERS

A Maine insurance employee asked for a promotion, but the higher-level job was given to someone else. The employee sued, citing several remarks made by the decision makers about her family responsibilities. Interestingly, all the people involved in this story are women.

WHAT HAPPENED

"Chapman" joined Wellpoint, Inc., a healthcare insurance provider, in 1997 and was promoted to "recovery specialist II" two years later. Her job involved pursuing third-party reimbursement and overpayment claims. In 2006, the position of recovery specialist lead became open, and Chapman felt she was the best qualified employee for it, having done many of its duties in the past. She had also received 4.40 out of 5.00 in her most recent performance evaluation.

A team of three supervisors interviewed Chapman and one other candidate for the job. All three were aware that Chapman was the mother of an 11-year-old and 6-year-old triplets. And, during and after the interviews, all three commented about her children. The job went to the other woman, who had less experience and a lower score on her most recent evaluation. Chapman sued, asserting they had violated federal and state civil rights laws by assuming her family would distract her from work. A federal district court judge dismissed her case, saying she couldn't prove the remarks were direct evidence of bias. She appealed to the 1st Circuit, which covers Maine, Massachusetts, New Hampshire, and Vermont.

WHAT THE COURT SAID

Appellate judges did not agree with the district judge. They saw plenty of evidence that the decision makers had stereotyped Chapman, particularly on the basis of the triplets. Wellpoint argued that the other candidate was also a mother with a 9-year-old and a 14-year-old. The primary decision maker testified that she found the other candidate's interview more professional and compelling than Chapman's. But Chapman testified the decision maker told her the other woman had been promoted because "you're going to school, you have the kids, and you just have too much on your plate right now." That sounded like bias to the judges, and they sent her case to a jury. Chadwick v. Wellpoint, U.S. Court of Appeals for the 1st Circuit, No. 08-1685 (2009).

POINT TO REMEMBER

The Equal Employment Opportunity Commission not long ago issued guidelines for employers on how to avoid prejudice or stereotyping based on an employee's family responsibilities, whether for children, elderly parents, or anyone else, and applying to both men and women. The agency noted that it was not creating new law in this arena, but simply expanding the definition of Title VII to clearly include such bias.

This article provided by BLR.

LEGAL & COMPLIANCE

GUIDANCE ON REQUIREMENT TO EXTEND DEPENDENT CHILD COVERAGE UNTIL AGE 26

The new health care reform law includes a provision requiring employer-sponsored group health plans that provide coverage for employees' children to make that coverage available until age 26, regardless of an adult child's marital or student status. On May 10, 2010, the three federal agencies responsible for implementing this provision issued interim final regulations interpreting this requirement and answering some important questions. Like the provision itself, the regulations are effective for plan years starting on or after September 23, 2010.

Highlights from the new guidance include:

- The contribution required for a dependent child's coverage MAY NOT vary based on a child's age so long as the child has not reached age 26. For example, a group health plan cannot require an employee to pay a surcharge for each child enrolled who is over age 18 (but under age 26).

- The coverage provided for adult children under age 26 MAY NOT vary based on age. For example, a plan that offers multiple options cannot restrict coverage of adult children to one of those options.

- Plans that have had lower limiting ages or have had student status requirements will be required to allow an opportunity for employees to enroll their adult children who are under age 26 if they were never eligible, or lost coverage, due to the more restrictive dependent eligibility provision. The regulations require plans to provide notice of the enrollment opportunity and specify the options that must be made available to those who qualify.

- A group health plan's eligibility provision MAY NOT restrict dependent eligibility based on a child's financial dependency, residency, student status or employment.

- A grandfathered plan may exclude dependent children who are eligible for an employer-sponsored health plan, but only if that plan is not the group health plan of a parent (for details on what plans are considered grandfathered, see **Willis' Human Capital Practice Alert, Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011")**.

For a detailed consideration of the new interim final regulations, please see the Willis Human Capital Practice Alert, Vol. 3, No. 8, by **clicking here**.

FTC POSTPONES ENFORCEMENT DEADLINE FOR "RED FLAGS" RULE

In response to Congressional request, the Federal Trade Commission (FTC) is further delaying enforcement of the "Red Flags" Rule (RFR). The newest postponement now delays the Rule through December 31, 2010.

The FTC explained that the delay is intended to offer Congress time to consider legislation that would affect the scope of entities covered by the Rule. This new enforcement delay is limited to the RFR and does not extend to the Rule regarding address discrepancies applicable to users of consumer reports (16 C.F.R.§641) or to the Rule regarding changes of address applicable to card issuers (16 C.F.R.§681.2).

BACKGROUND

The RFR was developed under the Fair and Accurate Credit Transactions Act, in which Congress directed the FTC to develop regulations requiring "creditors" and "financial institutions" to address the risk of identity theft.

The resulting RFR requires all such entities that have "covered accounts" to establish written identity theft prevention programs to help identify, detect and respond to patterns, practices or specific activities – known as "red flags" – that could indicate identity theft. In a nutshell, safeguards to be developed are intended to kick in when triggered by a "red flag" event; however, many are concerned that, though well intended, the red flags process could unintentionally inhibit other types of standard transactions. A variety of organizations are lobbying legislators to carefully evaluate the RFR's possible negative business implications.

ENFORCEMENT DATE

The Federal Trade Commission has previously issued notice delaying RFR enforcement. Most recently, the FTC announced in October 2009 that (again at the request of Congress), it was delaying enforcement of the Rule until June 1, 2010, to allow Congress time to finalize legislation limiting the scope of RFR-covered businesses. Since then, the FTC received a new Congressional request for enforcement delay beyond June 1, 2010, which has been approved and (as explained above) pushes enforcement back to the end of 2010.

With this newest action the FTC expressed an urgent request that Congress act to pass legislation that will resolve any questions as to which entities are covered by the Rule and eliminate the need for further enforcement delays. If Congress passes legislation limiting the scope of the RFR with an effective date earlier than December 31, 2010, then FTC will begin enforcement as of that earlier effective date.

NLRG examined possible RFR employee benefits ramifications in an article published late last year, available by **clicking here**.

The RFR's broad definitions have raised numerous questions about whether and how the RFR applies to various employee benefits programs. Although earlier FTC guidance has clarified that a 401(k) plans' accounts would not need to be included in a written identity theft prevention program, further clarification would be helpful about the RFR's application to other types of employee benefits programs. For example, Health Reimbursement Arrangements (HRAs), dependent care assistance spending accounts and transportation plans have not yet been addressed in available FTC guidance.

Until further clarification is available, published guidance addressing flexible spending accounts provides some insight for employers and TPAs when considering other account-based benefits and compliance with the RFR. In addition, employers may wish to consider possible issues that may attend to the use of a debit card in conjunction with a benefits program or if credit is extended or processed for an employee.

The FTC websites related to the RFR requirements, compliance and related identity theft issues include:

- **ftc.gov/redflagsrule**
- **http://www.ftc.gov/bcp/edu/pubs/business/alerts/alt050.shtm**
- **http://www.ftc.gov/redflagsrule**
- **http://www.ftc.gov/bcp/edu/microsites/idtheft/**

CBO REVISITS HEALTH CARE REFORM ESTIMATES – SOME COSTS DOUBLE

A Congressional Budget Office (CBO) report recently sent to the House Appropriations Committee said the estimated rise in federal discretionary spending connected to the new health care reform law over the first 10 years of implementation may actually exceed $115 billion. Only two months earlier, the non-partisan CBO reported that the estimated increase for discretionary spending might run approximately $55 billion. The new report essentially doubles the original estimated increases of some costs resulting from health care reform legislation enacted last March. Some Republican lawmakers have complained about being misled on costs since the CBO estimates measure spending that requires annual Congressional authorization.

The CBO director said the latest report "updates and expands" on earlier findings. He explained that the original under-calculation was always characterized as speculative because such appropriations require Congressional action and could be larger or smaller than initially anticipated.

The health care legislation was estimated by CBO to cost $940 billion over 10 years and reduce the federal deficit by $143 billion over the same period. A variety of news organizations have covered the revised CBO estimates, including CNN. To view their report **click here**.

Many observers note that the government has a notoriously poor record for under-calculating such anticipated costs, as demonstrated in Medicare and Medicaid calculations and costs associated with the Massachusetts health care reform program.

IRS: NO HSA INFLATION ADJUSTMENTS FOR 2011

By law, the IRS must publish the annual inflation adjustments relating to health savings accounts (HSAs) no later than June 1 for the following calendar year. The IRS announced on May 24, 2010 that there will be no inflation adjustments relating to HSAs for 2011. This is the first year since the laws governing HSAs were enacted in 2003 that there has been no change in these amounts. This chart summarizes the limits that apply this year and will continue to apply next year.

	SELF-ONLY	FAMILY
ANNUAL CONTRIBUTION LIMIT	$3,050	$6,150
HDHP MINIMUM ANNUAL DEDUCTIBLE	$1,200	$2,400
HDHP MAXIMUM OUT-OF-POCKET LIMIT	$5,950	$11,900
CATCH-UP CONTRIBUTION	$1,000	

The Annual Contribution Limit is the maximum amount of tax-favored contributions that can be made to an individual's HSA for a calendar year. Contributions from all sources are aggregated when determining if the limit is met. An individual may incur excise taxes on excess contributions. Catch-Up Contributions increase the Annual Contribution limit for individuals age 55 or older. The Catch-Up Contributions limit is not inflation-adjusted. When enacted, the limit was set at $500 for 2004, with $100 annual increases. In 2009, it reached the current $1,000 maximum.

The HDHP Minimum Annual Deductible and Maximum Out-of-Pocket Limit refer to features that a health plan must have in order to qualify as a high-deductible health plan (HDHP). Coverage under an HDHP is one of the conditions that an individual must meet in order to be eligible for tax-favored HSA contributions. The limits on these items are also inflation-indexed, with the potential to change each year. Employers that maintain HDHPs need to know these adjustments so that they can make any changes needed for their plans to remain HDHPs.

The IRS announces the adjustments for HSAs much earlier in the year than it announces the adjustments for other types of benefits programs. (Inflation adjustments for most plans usually are announced in October or November. See Willis ***HR Focus*, Issue 29, "Few Cost-of-Living Changes for 2010."**) The earlier timing of the announcement for HSAs is mandated by legislation that Congress passed at the end of 2006 (see Willis ***Employee Benefits Alert*, Issue 91, "Health Savings Account Legislation Makes HSAs More Flexible"**). The legislation revised the provisions governing HSAs so that the IRS now must publish the annual adjustments no later than June 1 for the following calendar year.

(Wellness–continued from page 1)

marketing materials at no charge, while others may charge additional fees for special requests, such as translation into other languages.

CUSTOMER SERVICE

Make sure the roles and responsibilities of both parties are specified prior to product/service delivery. A single point of contact or designated account manager is preferred. Ensure the vendor has a proven track record with organizations similar to yours as well as a minimum number of years in business.

TECHNOLOGY

Confirm that the vendor has secure, web-based applications that are easy for employees to access and use. Define the process for IT issues and support as well as data storage, transfer or integration capabilities.

EVALUATION AND REPORTING

Inquire about the accuracy and timing of data collection and reporting outcome. Confirm in writing what party (vendor or customer) owns the data. Ensure the vendor has procedures to protect integrity and confidentiality of the data, including HIPAA compliance.

COST/VALUE

Compare cost of the product/service with other vendors. Confirm all fees up front and that pricing will not fluctuate and is all-inclusive. It never hurts to ask for a performance guarantee, where costs to the customer are reduced if set standards are not met.

These are just a few of the important considerations in choosing the best vendor partner. To learn more, or to request assistance, please contact your Willis service team.

SINCE YOU ASKED:

WHAT'S THE DIFFERENCE BETWEEN AN SPD AND A PLAN DOCUMENT?

In short, a plan document is a written legal instrument under which an employer-sponsored benefits program is established and operated. By contrast, SPD stands for "Summary Plan Description." The SPD is a Cliffs Notes version of the plan document and is used to explain the provisions of a company-sponsored plan (such as retirement, health, life, disability, etc.).

ERISA mandates distribution of the SPD so that participants have an easy-to-use guide to rely on for plan-related information. An SPD is required to be distributed to all plan participants, pursuant to ERISA. It must be furnished within 90 days of becoming a participant in a covered benefits plan and must contain such information as the plan name, the name and address of the employer/plan sponsor and the plan year, as well as information on rights under ERISA, such as how to file a claim and what to do if a claim is denied.

Among other key provisions, the SPD contains a very clear description of important features of the plan, e.g., when employees begin to participate in the plan, how service and benefits are calculated, when benefits become vested, when payment is received and in what form. Participants must be informed of material changes, either through a revised Summary Plan Description or in a separate document called a Summary of Material Modifications.

Although federal law requires both a legal plan document and an SPD, many welfare plans (health, life, disability, etc.) do not have an SPD. Many also do not have a plan document. In some cases, the client relies on the insurance contract for the document and the certificate given to employees as the SPD. This is a dangerous practice. The insurance certificate will NOT have all of the information required by ERISA to be included in an SPD.

WEBCASTS

*NOTE: **There is no webcast scheduled for July.** The educational webcast series will resume in August with the topic shown below..*

THE SELF-FUNDED VS. FULLY-INSURED PROPOSITION – WHAT IS BEST FOR YOUR MEDICAL PLAN

AUGUST 17, 2010
2:00 PM EASTERN TIME

Presented by
Roland Birkner, National Underwriting Practice Leader
David Kwant, Reporting and Underwriting Manager

Fully-insured? Partially Self-funded? Minimum premium? What is the best funding arrangement for your medical plan? Which type of funding arrangement would give your plan the best opportunity to succeed both financially as well as with employee satisfaction? Which are more important to your company and your plan:

- Premium stability?
- Ability for financial gains in good claim years?
- Choice of networks and vendors?
- Unbundling?
- Plan design flexibility?

In this session we will discuss the advantages and disadvantages of self-funded and fully-insured medical programs. We will explain self-funding concepts, including stop loss protection and the differences between funding arrangements relative to plan design, financial forecasting and renewal calculation, administrative efforts and fiduciary responsibility. We will also talk about the merits of bundling or un-bundling the components of a self-insured program (claim administration, prescription drug plan, stop loss, utilization review, disease management and wellness). At the end of the session, you should have an understanding of whether or not self-funding is appropriate for your plan.

PARTICIPANT ACCESS

Advance reservations are required to participate. **Click here** to RSVP for this call.

KEY CONTACTS

US BENEFITS OFFICE LOCATIONS

NEW ENGLAND

Auburn, ME
207 783 2211

Bangor, ME
207 942 4671

Boston, MA
617 437 6900

Hartford, CT
860 756 7365

Manchester, NH
603 627 9583

Portland, ME
207 553 2131

Shelton, CT
203 924 2994

NORTHEAST

Buffalo, NY
716 856 1100

Cranford, NJ
908 931 3005

Florham Park, NJ
973 410 4622

Morristown, NJ
973 829 6374
973 829 6465

New York, NY
212 915 8802

Norwalk, CT
203 523 0501

Radnor, PA
610 254 7289

Wilmington, DE
302 397 0171

ATLANTIC

Baltimore, MD
410 584 7528

Bethesda, MD
301 581 4261

Knoxville, TN
865 588 8101

Memphis, TN
901 248 3103

Nashville, TN
615 872 3716

Norfolk, VA
757 628 2303

Reston, VA
703 435 7078

Richmond, VA
804 527 2343

Rockville, MD
301 692 3025

SOUTHEAST

Atlanta, GA
404 224 5000

Birmingham, AL
205 871 3300

Charlotte, NC
704 344 4856

Gainesville, FL
352 378 2511

Greenville, SC
704 344 4856

Jacksonville, FL
904 355 4600

Marietta, GA
770 425 6700

Miami, FL
305 421 6208

Mobile, AL
251 544 0212

Orlando, FL
352 378 2511

Raleigh, NC
704 344 4856

Savannah, GA
912 239 9047

Tallahassee, FL
850 385 3636

Tampa, FL
813 490 6808
813 289 7996

Vero Beach, FL
772 469 2842

MIDWEST

Appleton, WI
414 259 8837

Chicago, IL
312 288 7700
312 621 4843
312 348 7678

Cleveland, OH
216 357 5921

Columbus, OH
614 326 4788

East Lansing, MI
517 349 3226

Grand Rapids, MI
248 735 7249

Green Bay, WI
414 259 8837

Milwaukee, WI
414 203 5248
414 259 8837

Minneapolis, MN
763 302 7131
763 302 7209

Moline, IL
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412 586 3524

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972 715 6272

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303 773 1373

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713 625 1017
713 625 1082

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956 682 9423

Mills, WY
307 266 6568

New Orleans, LA
504 581 6151

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210 979 7470

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602 787 6078

Los Angeles, CA
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415 493 5210

Phoenix, AZ
602 787 6235
602 787 6078

Portland, OR
503 274 6224

Rancho/Irvine, CA
562 435 2259

San Diego, CA
858 678 2000
858 678 2132

San Francisco, CA
415 291 1567

San Jose, CA
408 436 7000

Seattle, WA
800 456 1415

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