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#### Health Plan Mismanagement Lawsuit

Riscomp Industries, Inc. which operated under the name RJ Associates, was a Minnesota corporation providing professional employer services to clients in 13 states. The health plan was a multiple employer welfare arrangement (MEWA) that provided medical, dental, life and death benefits to almost 1,800 participants before Riscomp declared bankruptcy.

Former Riscomp executives are being sued by the U.S. Department of Labor for mismanagement of the firm's health plan that left plan members with more than \$2.1 million in unpaid health claims. The suit alleges that three top executives violated ERISA when they allegedly embezzled more than \$1.2 million of health plan contributions. At the time of the purported violations, the defendants also served as trustees to the health plan.

If successful, the suit will require the executives to pay for any losses, including interest, and to undo any prohibited transactions with the plan. It will also permanently bar the defendants from service as fiduciaries or service providers to any ERISA-covered plan in the future. The suit also asks the court to remove Riscomp as the plan's administrator, to appoint an independent fiduciary to manage the plan, and to require the former executives to pay the costs of the independent fiduciary. The bankruptcy trustee also agreed to restore \$86,000 in assets transferred to Riscomp's bankruptcy estate.

#### Aggressive DOL Auditing

Since 2000, Employee Benefit Security Administration (EBSA) has launched an enforcement initiative specifically targeting health plans. Currently, EBSA is targeting both pension plans and health plans due a number of high profile cases in the ERISA area and the numerous bankruptcies filings, (as substantiated by the previous article). Regardless of whether a plan sponsor files for bankruptcy, EBSA conducts "random target audits" of health plans merely to ensure timely

payments and generally to spot check compliance with ERISA and HIPAA. Additionally, the DOL has initiated audits aimed at finding and monitoring Multiple Employer Welfare Arrangements (MEWAs) and assuring compliance.

One audit priority is the overall plan documentation and compliance with the reporting and disclosure requirements of ERISA. Many plan sponsors do not have formal ERISA plan documents but simply substitute booklets supplied by the insurance carriers. These booklets often do not meet ERISA's many compliance standards and requirements. Booklets issued by the insurance carrier are often blanket insurance policies or contracts created by the insurer for the majority of their clients. They are rarely tailored to the client's specific needs so many plan sponsors are not operating their plan in conformity with their plan document — a fundamental ERISA fiduciary violation.

Moreover, health plan documentation created by an insurance carrier is often not in compliance with all of the legal requirements of ERISA and the Health Insurance Portability and Accountability Act (HIPAA). Generally, the focus of the insurance carrier is on satisfying applicable state insurance law as opposed to addressing ERISA requirements which must be contained in the plan documentation.

Plan sponsors with numerous insurance contracts should consider having a “wrap plan” drafted for their health plan. A wrap plan is an ERISA plan document that contains all the necessary legal requirements of ERISA in addition to incorporating all of the insurance certificate booklets by reference. This in effect bundles the insurance contracts for compliance purposes, creating a cost effective alternative for ERISA compliance. With the creation of a wrap plan, the plan sponsor need only file one Form 5500 with various Schedules A for each insurance contract offered.

Wrapping all plans together works nicely for ERISA purposes; for certain HIPAA privacy purposes it adds a step to HIPAA privacy and security-related compliance. If group health plans and non-health plans are bundled, the sponsor must be sure to designate the plan as a hybrid plan for HIPAA purposes. Although a hybrid designation must be included in the “wrapper” plan document, the health plan will still be treated in all other aspects under HIPAA as a separate plan.

Further ERISA violations include the following:

- Failing to operate the plan prudently and for the exclusive benefit of participants.
- Using plan assets to benefit others, including the plan administrator, the plan sponsor, and parties related to these individuals.
- Failing to properly value plan assets at their current fair market value, or to hold plan assets in trust.
- Failing to follow the terms of the plan.
- Failing to properly select and monitor service providers.
- Taking any adverse action against an individual for exercising his or her rights under the plan (e.g., being fired, fined, or otherwise being discriminated against).

EBSA also conducts investigations of criminal violations such as embezzlement, kickbacks, and false statements under the U.S. Criminal Code.

### **Employer-Backed Health Care: Here to Stay?**

To paraphrase Mark Twain, the demise of the employer-provided benefit plan has been greatly exaggerated. The *New York Times* recently published an article proclaiming that employer-based health benefit coverage was likely around to stay. The article relies mainly on opinions from policy analysts and con-

sultants in Washington and around the country. The reason they give is that none of the other possibilities, like a government-run plan or some new private-sector solution, have enough support to serve as a replacement.

Inspiring the latest round of debate is the proposal introduced last month by the President's Advisory Panel on Federal Tax Reform. Under the proposal, tax breaks for both employers and their workers for health benefits are limited to \$11,500 of coverage for a family and \$5,000 for an individual. Under current tax law, there are no limits to how much coverage is exempt from payroll and income taxes.

Although many legislative observers say the proposal has no chance in Congress, some critics see the fact that the measure is being proposed at all as an early indication that an already unraveling system will continue to weaken. (Only 60 percent of employers now offer coverage, compared with 66 percent as recently as 2003, according to annual survey conducted by the Kaiser Family Foundation.) Large companies, particularly those that have long offered generous benefits to employees as part of their compensation, are watching carefully.

Under the proposal being considered by Congress, today's typical group health plan is not generous enough to be taxed. Some consultants warn that health-care inflation could push many plans past that limit and create a problem for employers in the future. Companies are also wary of Congress making health benefits count toward income subject to Social Security taxes.

The current proposals only make the benefit over a set amount taxable to the employees. The expectation is that if employees are taxed on the benefit anyway, they may begin to demand cash instead — hastening the move toward lower benefits.

Employers are becoming bolder about experimenting with strategies to shift more of the additional costs onto their workers. At least one of these tools, health savings accounts, would be eliminated under the tax advisory panel's plan. The proposal favors a broader savings vehicle, paid through after-tax dollars that could be used by families for more than health care expenses. (Many observers already acknowledge HSAs as a proven success. See, the *Wall Street Journal's* article of December 7, 2005.)

Corporate executives and many others are leery of a government solution, but no one has come up with a private-sector option that has gained significant support. Because individuals who buy private insurance on their own pay much higher prices than the group rates employers get, many people could probably not afford health insurance if their employers were not involved in the purchase.

Political odds are against any major tax reforms occurring anytime soon. The debate over the fairness of the current tax system — which tends to benefit employees with employer-backed coverage, is not a new one.

### **BC/BS Bank**

The *Washington Post* reports that the Blue Cross and Blue Shield Association wants to launch a bank to administer its consumer-directed health plans. The aim is to simplify the administration of health savings accounts and other similar plans offered by Blue Cross insurers throughout the United States.

The bank would give those enrolled in Blue Cross plans a familiar, centralized financial institution to monitor and access their accounts. Currently, the Health Spending Accounts (HSAs) offered by Blue Cross insurers are handled by third-party banks. Creation of the bank is subject to regulatory approval.

The move into financial services is expected to be lucrative for Blue Cross. By 2010, HSA accounts

could be holding as much as \$75 billion in assets, according to a consulting firm report cited in the article. As a result, financial institutions could stand to collect up to \$3.5 billion from asset management and account fees.

About one million people have enrolled in HSAs and other similar plans since 2003, and roughly 40 percent of them are with Blue Cross insurers. Blue Cross hopes to have its bank up and running by the summer of 2006.

### **Surgery Preview: Is Seeing Believing?**

Get ready for the latest wellness/educational benefit offered by certain health insurers and employers: video clips of live surgery. The videos range from animated simulations to live action.

Although the goals are to encourage healthy behavior to avoid surgery, to encourage individuals to consider alternatives, and to encourage informed questions for the surgeon — the method may not work for everyone. Some people will view the approach as “over the top.” Some physicians have expressed concern that the shock value may scare people away from needed surgery.

### **Postponing the Medicare Prescription Drug Benefit?**

Just as enrollment for Medicare’s new prescription drug benefit is underway, a small group of Republican senators have proposed legislation to defer the program for two years. This is part of a cost-saving measure to offset the relief and recovery costs of recent hurricanes.

The proposed bill (S. 1928), is sponsored by Senator John Ensign (R) and co-sponsored by Senators Brownback, Coburn, Cornyn, DeMint, Graham, McCain, and Sununu. Although the Medicare Part D proposed deferment has received the most notice, this bill includes other cost-saving provisions.

In general this bill provides for:

- A five percent reduction in the fiscal year 2006 budget for each discretionary account (with certain exceptions such as appropriations for the Department of Homeland Security and the Department of Defense)
- A freeze in 2006 in the cost of living adjustment in basic rates of pay for Federal employees (except for Federal Law Enforcement Officers)
- A two-year delay in implementing Medicare Part D and two-year extension of the drug discount program; the transitional relief for low-income individuals would be increased from \$600 to \$1,200
- Repeal of certain sections of the *Transportation Equity Act*
- Establishment of a commission to review federal agencies

Most commentators still assert that this proposal lacks meaningful support. President Bush and Congress worked very hard to get the prescription drug benefit legislation passed in 2003, and it is doubtful that Congress would want to rescind its commitment to 43 million Medicare beneficiaries, many of whom vote.

## **FMLA Intermittent Leave**

Based on two recent polls, intermittent leave (which allows time off in intervals as small as six minutes), is regarded as the single biggest problem with the *Family and Medical Leave Act* (FMLA) for employers.

A survey conducted by the Society for Human Resource Management (SHRM) showed that 51 percent of over 350 HR professionals reported problems administering intermittent leave. Another prominent survey found half of employers want stricter guidelines on the use of intermittent leave.

For the most part, it appears that chronic conditions rather than life-threatening ones, are the recurring problem. For example, the scheduled chemotherapy session of a cancer patient is not an issue for employers. However, it is chronic conditions such as back pain, behavioral disorders, or diseases with subjective symptoms that prove difficult to administer and occur with little warning that are giving employers difficulty.

To curb suspected abuse of intermittent leave, employers should:

- Ask for medical recertification.
- Draft their FMLA request forms carefully to include language authorizing the employer to contact the employee's physician (which is recommended to be used only when abuse is suspected).
- Pay attention to the physician's specialization; be wary of certifications from physicians outside their area of specialization.
- Analyze absence patterns.

Finally, employers are allowed to temporarily transfer employees using intermittent leave to a position where the absence can be managed more easily. Keep in mind that the temporary position is not required to have equivalent duties, but the pay and benefits must be equivalent, and the transfer must not be punitive or retaliatory.

## **Proper Contraception Use Pays Health Care Dividends**

According to the Wellsource publication, *Connect.com*, workforce education to encourage consistent, effective use of contraceptives may cut huge costs associated with pregnancies, births, abortions and hysterectomies related to gynecologic disorders.

That article cites finding that indicate approximately 48 percent of all pregnancies are unintended, and 53 percent of unintended pregnancies are the result of contraceptive failure. Furthermore, the proportion of women using no contraceptive method grew from 7.5 percent in 1995 to 10.7 percent in 2002 — a time when employer-based coverage declined. Frequency of contraceptive use may be associated with an individual's medical coverage and out-of-pocket costs.

The intrauterine device, or IUD, is the most effective and least costly contraceptive method over time, but it gets very little use among American women — perhaps because of outdated safety concerns, said Dr. Raquel Arias, a gynecology professor at USC. Roughly 80 percent of insurers cover oral contraceptives, but only 40 percent to 50 percent cover newer methods, such as the latest IUDs. Perhaps, given the recent study results, it might make financial sense for employers to revisit those aspects of their plan design.

## **DOL: Benefits Outpace Other Compensation**

Rising employee benefit costs again outpaced overall compensation increases, including wage expenses, during the third quarter, according to a new Department of Labor report. Those increases in benefit costs will continue to constrain compensation increases.

Total compensation costs for private-sector workers rose 0.8 percent from June to September, compared with a 0.6 percent gain the previous quarter. Compensation costs for state and local workers rose 1.1 percent from June to September — greater than the 0.7 percent gain during the previous quarter.

However, benefit costs for private-sector employees rose 1.3 percent during the third quarter, according to the index. That followed a “more moderate” gain of 0.8 percent the prior quarter, the report said. The costs for state and government workers rose 1.7 percent in the September quarter, up from 1.2 percent during the previous period.

Meanwhile, wages and salaries for private-sector employees increased 0.6 percent during the last quarter, unchanged from the previous two quarters. Wages for state and local government workers rose 0.7 percent from June to September, following a 0.5 percent increase the previous quarter.

## **California Paid Leave Program Attracts Few**

About 1.1 percent of eligible employees took advantage of California’s paid leave family insurance program in its first year, according to the State Employment Development Department’s (EDD) projected estimates. (For more information about California’s paid family leave law, please see *Willis EB Alert #6* and #17.)

Nearly 138,000 workers out of a total covered work force of close to 13 million employees received about \$300 million under the program, the nation’s first, which is funded by the workers themselves under the State Disability Insurance program.

The law, which took effect July 1, 2004, guarantees workers in California six weeks of 55 percent of their weekly pay, up to a maximum of \$849 a week, if they need time to care for an ill child, parent, spouse or registered domestic partner, or to bond with a new minor child. Workers can take off six consecutive weeks, or divide the leave into smaller time periods. The benefit is funded through employee payroll deductions.

According to the EDD, more than 88 percent of the paid family leave insurance claims were for bonding with a new child. Of these, 83 percent were from mothers and 17 percent from fathers. Nearly 12 percent of the workers took leave to care for a seriously ill family member, of whom 70 percent were women and 30 percent men.

The paid leave program does not directly provide job protection or return rights, but most many workers will have their jobs protected by the federal Family Medical Leave Act and the California Family Rights Act. (Employees are required to take leave under FMLA and the CFRA at the same time they receive paid family leave insurance benefits.)

The EDD did not indicate how many employees return to work after their paid leave. However, organizations report problems regarding people who are kept on the employer’s payroll for months and even years after they stopped working because of a disability, workers’ comp, etc.

In many cases the employer is trying to be helpful and continue to extend benefits to those people.

However, this practice opens the employer up to discrimination claims, ongoing medical costs, refusals by insurers to pay the costs because the people are no longer eligible, extended COBRA liability, questions about severance, retirement plans, and more. The best practice is to terminate those employees as soon as allowable.

### **Creditable Coverage Notice**

Medicare Part D is part of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA). The MMA authorizes a new benefit for retirees to have a substantial portion of their prescription drug costs covered by Medicare for the first time.

The MMA includes additional requirements for all employer-sponsored group medical plans, not just retiree medical plans. Central among these requirements is a rule that directs employers to tell their workers whether the coverage in their plan is creditable (essentially equivalent to the federal Medicare benefit). All employer sponsored plans must *also* annually advise the Centers for Medicare and Medicaid Services (CMS) as to whether or not their plan(s) provide creditable coverage. We have had numerous requests for information about the MMA-mandated creditable coverage notification process, but CMS has not yet published guidance.

We recently sent CMS a written request that they provide details about when plan sponsors might expect to receive the promised guidance. CMS responded with the following statement:

“CMS expects to publish guidance soon that specifies both the deadline and the method for submitting creditable coverage information to CMS. The guidance will be posted on the Creditable Coverage webpage at <http://www.cms.hhs.gov> . Until that guidance is issued, prescription drug plan sponsors should not attempt to submit creditable coverage information to CMS because the attempted submission will not be in the form or manner that will be specified in the upcoming guidance.”

### **Building a Healthier You: One Step at a Time**

The *Wall Street Journal* recently reported on a new engineering trend in architectural construction. Instead of designing buildings that simply get people from Point A to Point B as quickly and easily as possible, companies have a new objective: encouraging the building's occupants to be more physically active.

Companies that commission the construction of their work facilities are using building design as a vehicle for promoting a healthier work force. Specifically, in an effort to stem the rise in obesity and its negative effects, there is a growing interest in ‘health-related design.’ This type of design includes incorporating walkways to connect buildings and making the use of stairs a more appealing alternative to elevators by changing the design of the stairs to make them easier to climb, having elevators less centrally located — and even making the elevators move more slowly than usual.

Various studies conducted in this area have shown that these design changes have noticeable and beneficial affects on a person's health. At a time when leisure-time physical activity in the United States is falling considerably, walking up stairs may be the only significant exercise many employees get. It is estimated that climbing up stairs for just two minutes a day lets a person burn an extra 5,800 calories, or 1.6 pounds, a year. This could mean that the average one pound per year weight gain of Americans could be eliminated.

## Since You Asked: HDHPs and Medicare Part D

A *FOCUS on Benefits* reader recently posed a question that has surfaced with some regularity as plan sponsors work to comply with the requirements of the *Medicare Modernization Act* (MMA) and its requirement that all group health plan sponsors send out notices of creditable or noncreditable coverage to each plan participant. The plan sponsor has asked how the carrier could maintain that the benefit is creditable, what its next steps should be, and who would be liable for an incorrect determination of creditable or non-creditable status?

### General facts

A plan sponsor offers a high deductible health plan (HDHP) which includes a deductible of \$1,500 (single) and \$2,200 (family). The HDHP has an integrated prescription drug benefit, and the fully-insured carrier has provided information to the plan sponsor, indicating that the HDHP provides creditable coverage. Because the IRS considers the availability of “Rx coverage” a feature that makes a participant ineligible for HSA eligibility, the HDHP plan being considered for purposes of this question does not permit the use of an HSA. The client is cautious about sending out notices of creditable coverage because it suspects that the carrier might have incompletely reviewed the plan’s structure.

### Analysis

Plan sponsors should remember that there is a four-part “do-it-yourself” test for benefit creditability. One of those parts involves a determination of whether the benefit plan is designed to pay an average of 60 percent of participants’ prescription drug claims. It is very possible that the fully-insured carrier took a cursory look at the benefit structure that it was providing and that it made a determination that the benefit structure passed this prong of the four-part test. Unfortunately, the 60 percent test is only part of the analysis.

Most high deductible health plans will have a deductible that is higher than \$250 (to be a “high deductible health plan” for Health Savings Account purposes, the minimum deductible must be at least \$1,050 in 2006). In the case of HDHPs with an integrated prescription drug benefit, to pass the four-part test the integrated health plan cannot have more than a \$250 yearly deductible. Accordingly, almost any benefit that is referred to as a high deductible health plan (especially HDHPs under an HSA) will fail to pass the four-part creditability test.

Plan sponsors with a benefit structure that fails to pass the four-part test have two options:

1. They can send out notices of noncreditable coverage to all participants; or
2. They can consider the option of hiring an actuary to perform testing and provide an actuarial attestation that the coverage is creditable on that basis.

Although it is possible that some HDHPs will pass the actuary’s testing — and be determined to be creditable — there is a cost associated with this option. Plan sponsors that are not applying for the Medicare Part D subsidy may determine that an actuarial confirmation is not worth the cost to the plan.

Generally, plan sponsors of fully-insured benefits are relying upon the carriers to determine whether or not the coverage is creditable — in most cases, such determinations by carriers are correct. However, as is this case, plan sponsors should review the carrier’s creditability determination, especially in instances where a HDHP is offered. Ultimately, the burden to produce accurate notices of creditable coverage falls on plan sponsors. Employers should ask questions if they suspect the accuracy of any determination.

## 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	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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