FOCUS On Benefits

April, 2007

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Health Care: Key 2008 Election Issue

As the 2008 Presidential campaign takes form, health care coverage for the uninsured is one of the most sizzling of political hot potatoes. The *Wall Street Journal* notes that former Senator John Edwards (D-NC) says providing health coverage to the estimated 47 million uninsured Americans is worth raising taxes to do it. Senator Barack Obama (D-IL) says he is determined to enact universal health care by the end of his first presidential term. Senator Hillary Clinton (D-NY) characterizes universal coverage as “not only a moral and health imperative, but an economic and jobs imperative as well.”

At least two Republican candidates — former governors Mitt Romney of Massachusetts and Tommy Thompson of Wisconsin — are expected to use their extensive track records on the issue as campaign selling points. The *Wall Street Journal* also states that with all the attention centered on obtaining coverage, presidential candidates may miss a more fundamental issue — health care cost. Numerous surveys emphasize that voters with health insurance are most concerned about curbing skyrocketing medical costs. No candidate has yet put forward a comprehensive plan to help control medical costs.

Our next president may have difficulty making either desire a reality. Although there is agreement about health care problems, how to fix them remains elusive and potentially polarizing to the electorate.

Tax Guidance Costs Tax Dollars

Reports of the IRS’ progress toward health savings accounts (HSAs) and cafeteria plan regulations are promising. According to an IRS official at a recent conference, new HSA and cafeteria plan guidance will be released within the next six months.

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HSA Guidance

- The HSA comparability regulations will change. Employers making HSA contributions outside of a cafeteria plan must contribute the same dollar amount, or percentage of the annual deductible, to employees' HSAs. December 2006 legislation made a change to these rules, allowing employers to contribute less to highly compensated employees' HSAs compared to other employees' HSAs.

- A "grab bag" of HSA guidance is also in process. This guidance will answer up to 50 questions that have not been addressed previously. These questions include:

  - May an employer recover HSA contributions it made by mistake?

  - Does an employee receiving medical care at an on-site clinic remain eligible for HSA contributions?

  - May individuals pledge their HSAs as collateral for loans?

Cafeteria Plan Guidance

- The IRS will be consolidating all previous cafeteria plan guidance — without any substantive changes. The IRS is also expected to make some changes to reconcile inconsistencies as the various pieces of guidance are collected.

- The consolidated cafeteria plan guidance will cover nondiscrimination testing. This will be the first time the IRS has addressed this topic, and it is likely to cause major headaches for plan sponsors.

- The IRS is also working on a "model cafeteria plan" that would make it easier for employers to add pre-tax options to their benefit offerings.

Because predictions about when tax guidance will actually appear are not always correct, cafeteria plans and HSAs will continue to raise questions for employers and employee benefits attorneys alike.

Lawmakers Considering New 401(k) Rules

The Government Accountability Office (GAO: formerly the General Accounting Office) 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 seeking to make fees and commissions related to 401(k) plans known to workers. Fees can drain thousands of dollars from an employee's retirement savings, so some legislators want firms overseeing 401(k) plans to provide that cost information in a clearer fashion. Existing law does not mandate the disclosure of fee details related to 401(k) plans to investors. Initiatives are in different stages of development, but proposals to improve the reporting of plan expenses are expected later this spring.

Congressman George Miller (D-CA), chairman of the House Education and Labor Committee, says it is important to see if all the fees are necessary and whether they are undermining workers' retirement funds. A committee meeting was recently held to assess the issue. A November 2006 report by congressional researchers found that roughly 80 percent of investors in 401(k) plans are unaware of how fees affect their accounts. The GAO has urged Congress to consider mandating the disclosure of 401(k) fee data such that investors could more easily compare plan options. According to the report, the Labor Department should make it compulsory that investors can obtain a synopsis of all fees paid: whether from plan assets or participants.

Republican committee members agreed that hidden fees should be studied, and that such action must be taken with caution so as not to jeopardize the economic future of more than 45 million Americans. Miller said the timing for a bill is not certain, but it is fairly safe to assume that he will try to get legislation passed in 2007.

$2 Billion in Health Care Fraud Recovered

The FBI ran almost 2,500 health care fraud investigations in 2006. So far, those investigations have yielded 600 indictments, 534 convictions, plus the recovery of more than $373 million in restitution, $1.6 billion in recoveries, $172.9 million in fines, and $24.3 million in seizures. The FBI started the investigations late in 2005 and recently published the FBI *Financial Crimes Report to the Public*, detailing its findings.

The FBI's Criminal Investigative Division is charged with government oversight and monitoring of health care fraud. Health care fraud is characterized as one of the agency's highest white collar crime priorities. Common health care fraud schemes include providing medically unnecessary services, billing for more services than were provided, submitting duplicate claims, and accepting kickbacks.

Employers Mull Retiree Health Coverage Options

Employers continue to cut back retiree health benefits. This trend is largely the result of ever-increasing healthcare costs running ahead of the inflation rate.

A recent Kaiser Family Foundation survey by measured the responses of 302 firms (with 1000 or more employees) that currently provide retiree health coverage to 5.2 million retirees and dependents. The results indicate that 78 percent of the surveyed firms expect to continue to provide retiree health benefits and to accept payments from the Retiree Drug Subsidy (RDS) program in 2007. This result is down slightly from last year's 82 percent.

While a healthy percentage of firms intend to continue retiree health benefits in 2007, 64 percent also expect to increase retiree contributions. In addition, 26 percent will increase cost-sharing requirements, 20 percent will increase prescription drug co-payments, and 18 percent will raise out-of-pocket limits. *New* retirees at the surveyed firms — including both pre-65 and Medicare eligible — will be paying an average of 41 percent of the total benefit cost.

Plans for the future include taking steps to reduce the number of those who will become eligible for retiree health coverage. In fact, ten percent of the companies reported that they are likely to eliminate company subsidies for a future group of retirees.

This survey also looked at the plan provisions for retiree coverage when a retiree enrolls in a Medicare prescription drug plan in 2007. Among the surveyed firms that receive the RDS subsidy payment, 36 percent would make the retiree ineligible for *all* medical coverage and 32 percent would make the retiree ineligible for prescription drug coverage only. In addition, 82 percent of the companies stated that if the retiree enrolls in a Medicare prescription drug benefit, the spouse will lose eligibility for the employer-sponsored coverage. More than half (57 percent) of the Medicare beneficiaries will lose any future rights to the employer-sponsored plan if they enroll in a Medicare prescription drug plan. The decision of whether to enroll in a Medicare prescription drug benefit has long-lasting results for many individuals, and it is important that employers carefully communicate the consequences.

Paying to Pay for Health Care?

The *Boston Globe* reports that in Massachusetts, patients are asked to pay upfront for elective procedures not covered by insurance, and some are required to offer credit card information at check-in. Providers and hospitals in other states, like Texas and North Carolina, are taking it further — offering credit cards specific to medical procedures and treatments with the help of banking and credit card firms.

Citibank already issues Citi Health Card, which has monthly payments as low as $10 and a no-interest feature for those willing to pay down medical debts more quickly through higher monthly payments. As more and more employers reduce the benefits they cover for workers, lower and middle-income workers are expected to increase their credit card debts through medical expenses.

Health care industry experts note that credit cards make it easier for hospitals and doctors to receive their payments. At the same time, these credit card debts could consume workers' funds increasingly over the next few years and possibly lead to more bankruptcies. Tenet Healthcare Corp. and UnitedHealth Group are cooperating on a line-of-credit program that takes co-payments and other fees automatically out of payroll for some employers.

Survey: Female Workers Worry About Health Care Expenses

The AFL-CIO's *Ask a Working Woman* survey identified a common fear that spanned across all demographic and age group classifications. Working women expressed great apprehension about the increasing cost of their health insurance.

An astonishing 97 percent of the working women surveyed expressed some level of concern about their ability to keep up with the cost of health insurance. In addition, 65 percent of the respondents indicated that they would support laws instituting health coverage mandates or that would help individuals find and obtain cheaper health insurance.

Survey findings also noted that nearly two-thirds of respondents reported working long and often irregular hours and did not think that they had a voice about meaningful work-related issues. Specifically, survey respondents complained that health insurance, retirement plans and sick leave programs missed meeting their needs.

EEOC Discrimination Filings Rise

Published reports from the *Los Angeles Times* note that, for the first time since 2002, the total number of discrimination charge filings against private-sector employers received by the U.S. Equal Employment Opportunity Commission (EEOC) increased in 2006. Discrimination charges in almost all areas tracked by the EEOC were up in 2006 compared to 2005.

Reported complaints include the following:

- Discrimination filings based on race (27,238)
- Sex discrimination (23,247),
- Disability discrimination (15,625),
- Age discrimination (13,569),
- National origin discrimination (8,327) and
- Religious discrimination (2,541)

The agency awarded nearly $274 million to charging parties, with $44 million through litigation and $230 million through administrative enforcement. The full list of 2006 statistics is available online at: www.eeoc.gov/stats/enforcement.html.

Congress to Consider Paid Sick Leave

In 2003, California became the first state to mandate paid family leave. On February 5, 2007, the San Francisco paid sick leave ordinance took effect. In 2007, we anticipate an increase in the number of paid sick leave bills being introduced at the state and federal level, and in some cases at the municipal level as well.

Senator Edward Kennedy (D-MA) recently held a hearing before the U.S. Senate Committee on Health, Education, Labor, and Pensions about the *Healthy Families Act*. Provisions of this bill would mandates that companies with fifteen or more employees give those employees working a minimum of twenty hours per week at least seven sick days per year. Supporters cite the argument that workers need some minimum level of pay protection when sickness occurs. Critics contend that the law would promote workers “playing hookey” with employers footing the bill. Although this is not the first time that Senator Kennedy has proposed this measure, the Democrats are now holding Congress for the first time in twelve years and prospects for passage appear stronger than in the past.

At the state level, it is expected that several states will be proposing paid sick leave legislation. One proposal already introduced in Washington would give employees up to five weeks of paid family medical leave each year. The web site http://www.stateline.org/live/ lists other states expected to propose paid sick leave legislation in 2007 as Maine, Maryland, Massachusetts, Michigan, Montana, Vermont and Wisconsin.

Future FMLA Expansion?

Last December, the Department of Labor (DOL) officially solicited public comment about the Family and Medical Leave Act (FMLA). This is significant because the FMLA regulations have not been amended since they were implemented in 1993. Some interpret this as a sign that the DOL may be willing to make FMLA changes.

The FMLA grants employees, at companies with 50 or more workers, 12 weeks of unpaid leave in a 12-month period to deal with the birth or placement of a child for adoption or foster care, or a serious health condition of their own or of a close family member.

Many employers have struggled with understanding and properly administering the rights provided by the FMLA, particularly issues involving the definition of a serious illness, sufficient notice, and intermittent leave.

Although the DOL's invitation for comments applied to any aspect of the FMLA, it specifically requested comments regarding the following:

- The determination of who is an eligible employee;
- The definition of a serious health condition;
- The definition of a day's impact for purposes of calculating leave and defining a medical condition;
- The impact of substituting paid leave for unpaid FMLA leave;
- The impact of the FMLA on attendance policies;
- Different types of FMLA leave, including intermittent, continuous, scheduled and unscheduled leave;
- Whether light duty should count against an employee's leave entitlement or reinstatement rights;
- Modification of job duties for an employee who is unable to perform the essential functions of a job;
- The impact of waiver of rights provisions;
- Communication between employers and employees;
- The burden on employers for making FMLA leave determinations and reviewing medical certifications; and
- FMLA impact on employee turnover and retention.

Some believe that power in Congress is so split that building a consensus to enact legislation to retool the FMLA is unlikely. Others believe that the DOL has taken this initial step to offer Congress a cue that FMLA revisions are warranted. We will continue to monitor this and keep you informed of any developments.

EAPs: ERISA and COBRA Implications

We were recently asked whether Employee Assistance Programs (EAPs) are employee benefit plans for purposes of ERISA coverage. Historically, this company had just assumed that its program was not an ERISA plan and had not complied with ERISA. Employers should note that, except in cases where the employer is able to demonstrate that its involvement is *very* limited, EAPs may have ERISA ramifications.

ERISA Background

A welfare plan, as governed by ERISA, is defined to include a plan established or maintained by an employer for the purpose of providing medical and other benefits (such as benefits in the event of disability, accidents, and death, to list a few). The DOL has generally found that EAPs can be ERISA plans.

For example, the DOL has found that "mental health services" can constitute medical benefits for ERISA purposes. EAPs that offer counseling benefits often fall into the ERISA plan category. It is important to note that offering an ERISA-type benefit is only part of the analysis. An EAP program that offers an ERISA-type benefit may still be exempt from ERISA if the arrangement falls outside the ERISA definition of welfare plan. The follow-up question becomes whether the EAP program is "established or maintained" by the employer.

Where an employer merely discloses an employee assistance program to employees, it is not offering an ERISA plan. For example, no ERISA plan would exist where an employer simply provided its employees with a phone number to call in order to be given referrals to agencies providing assistance to employees. If an employer does not employ any counselors, in-house or otherwise, and provides only referrals to counselors, then no ERISA plan exists.

On the other hand, if an employer provides counseling through contracted services or by hiring a counselor, or if the employer creates an administrative framework for the provision of these benefits, the program may become an ERISA program. As an ERISA plan the arrangement would be fully subject to the disclosure, reporting, and fiduciary standards of ERISA.

COBRA Analysis

Should an EAP be maintained by an employer and provide medical care, it will generally be considered a group health plan under COBRA. An employer who fails to offer qualified beneficiaries the right to continue coverage (or access) to such an EAP program risks the full-range of COBRA penalties.

Plan sponsors may wish to limit their involvement with EAPs to avoid transforming such programs into ERISA plans. The unexpected ERISA burden that can be attached to EAPs may persuade some employers to discontinue the benefit. However, effective and efficient solutions may be available, such as incorporating the EAP into a wrapper document that includes all the employer's other welfare benefit plans. Because the employer is already complying with ERISA for those plans, the EAP will generally not add much more of an administrative burden.

Issue Spotlight: HSA Contribution Limits

The following are the facts from a real client situation about Health Savings Accounts (HSAs). The employer's dilemma and our response is likely to be helpful in many situations relating to monthly HSA contributions.

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The Situation

On January 1, the employee chose family high deductible health plan (HDHP) coverage for himself and his wife (coverage beyond employee-only coverage was “family” coverage). The employee’s wife died that same month.

When the employee returned from bereavement leave, he wanted to make his health savings account (HSA) election for both January and February, and he asked his HR office how much he could contribute. He wanted to know if he could contribute the family HSA contribution for the whole year because he started the year with family coverage. Alternatively, he wanted to know if his contribution maximum would change after his wife’s death. This employer recalled reading something about recent December 2006 legislation removing any monthly pro-rata calculations of employee HSA contributions.

Our Response

When an individual enrolls in a HDHP and is eligible for an HSA at the beginning of the plan year, the participant’s monthly contribution limit is calculated on a monthly basis. This limit depends upon what level (individual or family) of HDHP coverage is in place on the first day of that month.

As presented by the employer, the participant’s contribution for January would be one-twelfth of the annual family HSA maximum contribution for 2007 ($5,650). So, the employee could contribute $470.83 for the month of January.

Because the employee’s wife died in January, he would have had employee-only HDHP coverage in place on February 1. His contribution for February would be one-twelfth of the annual employee-only HSA maximum contribution for 2007 ($2,850). So, he would be able to contribute $237.50 for the month of February and beyond.

The client’s confusion regarding pro-rata contributions and the December 2006 legislation was understandable. However, this new legislation abolished pro-rated contributions only within a very narrow context.

The legislation described how HSA contributions would be handled in the event that an individual gains eligibility after the beginning of the plan year. This would happen in a couple of ways:

- The individual gains eligibility for the HSA mid-year because he or she is a new employee; or
- The individual becomes eligible for the HSA mid-year because of a change in status event where the employee elects a HDHP.

When an individual gains eligibility after the beginning of the plan year, as long as the individual is eligible for the HSA on the first day of the last month of the plan year, then the individual can fully fund the HSA for the whole year.

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Applying the new HSA guidance (which went into effect on January 1, 2007), an individual who gains eligibility after the beginning of the plan year will be better off than a person who goes from family to employee-only HDHP coverage.

Let's consider what could happen to the employee in this client's situation. If, at his wife's death in January, he made a different benefit election (to a non-HDHP) within the time period required by his plan, then he would no longer be eligible for the HSA in 2007 and could not make any more contributions to his HSA. However, if he remarried in November of 2007, he would once again experience a change in status event that would permit him to once again choose a different health insurance plan. If he chose to re-enter the HDHP and elected family HDHP coverage that was in place on December 1, 2007, he would once again be eligible to participate in an HSA and would be permitted to contribute $5,650, the family coverage HSA maximum contribution for the year.

The December 2006 HSA legislation is favorable for individuals who become eligible for the HSA mid-year. The scenario is much less favorable for the employee directly affected in this employer's question.

U.S. Benefit Office Locations

Atlanta, GA (404) 224-5000	Austin, TX (800) 861-9851	Baltimore, MD (410) 527-1200	Birmingham, AL (205) 871-3871
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
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