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President Bush Announces Broad Health Benefits Proposal

President Bush announced new proposals for promoting health coverage during his recent State of the Union address. Although no actual legislation has been introduced, many employers have expressed interest in some of the proposals. The health care proposals would generally make it easier for states to expand health insurance coverage by redistributing federal funding, while also establishing new standardized plans intended to make private health insurance more affordable. However, they also build on the current system of employment-based health insurance coverage.

The most significant component of President Bush's health care proposal centers on instituting a federal tax deduction of \$7,500 for individuals and \$15,000 for families who obtain health insurance on their own or through an employer, regardless of the cost of the coverage. The proposal would also include the value of employer-sponsored health insurance in an employee's taxable income. (Most employees are not taxed on the value of their employer-sponsored health insurance under the protection of long-standing, deeply entrenched tax code provisions.)

Under the President's proposal, individuals and families with employer-sponsored health insurance plans worth more than the planned allowable deductions would pay taxes on the difference. The tax deduction would be available to all individuals and families who purchase health insurance, regardless of the value of their policies or whether they itemize deductions on their tax returns. Although there is some uncertainty about how the new tax program would affect people who do not have any tax liability due to low income or unemployment, some legislative observers anticipate that for the proposal to win Congressional approval such individuals would have to receive a refundable tax credit. For taxpayers that receive employer-based health insurance, the deduction would be offset by the cost of their coverage. News reports following the address seemed to indicate that the planned tax changes are intended to have a neutral tax impact over the first ten years following implementation.

While the Bush proposal is a long way from enactment, we believe that it is certain to re-ignite debate about reforms intended to promote health care coverage. Further information about the President's health proposal has been posted on the

White House's website: <http://www.whitehouse.gov/stateoftheunion/2007/initiatives/index.html>

Merger Agreement Amends ERISA Plan

A recent Fifth Circuit Court of Appeals decision — *Halliburton Company Benefits Committee v. Graves*, 2006 U.S. App. LEXIS 22318 — has shaken those contemplating a merger or acquisition. The court found that a merger agreement mentioning continuation of benefits amended the selling company's ERISA plan and limited future benefits actions. Later, when the acquiring company tried to modify the benefits, the plan participants had the right to challenge the changes by exercising their ERISA rights.

Background

Dresser Industries merged with Halliburton in 1998, adopted the Halliburton name and entered into an agreement about continuing the Dresser Industries, Inc. Welfare Benefit Plan. The merger agreement stated that the Dresser retiree plan could be amended if the Halliburton plan for active employees was amended. The court interpreted that provision to mean that the Dresser plan could only be changed if Halliburton's active plan was changed because the merger agreement statement had effectively amended the Dresser plan. This was despite the reservation of rights clause (permitting the employer to amend or terminate the plan at anytime) in the plan document itself.

Almost immediately following the merger, Halliburton began making administrative changes. More than five years after the merger, Halliburton amended portions of the plan reducing the Dresser retiree medical benefits to "achieve parity for all retirees." It was this action that started the legal dispute over whether Halliburton had the right to reduce the Dresser retiree benefits.

The Fifth Circuit's decision centered on a statement that limited the plan modifications that could impact the Dresser retiree medical plan. That statement required Halliburton to, "maintain with respect to eligible participants (as of the date of the merger) the [Dresser] retiree medical plan, except to the extent that any modifications thereto are consistent with changes in the medical plans provided by [Halliburton] and its subsidiaries for similarly situated *active* employees...." [Emphasis added.]

Ultimately, the court found that the merger agreement had been signed by those with the legal power to amend the terms of the benefit plan, and the merger agreement/plan amendment had been ratified in two significant ways:

- The shareholders of Halliburton and Dresser had approved the merger agreement four months after the agreement was executed; and
- Halliburton administered its obligations under the Dresser retiree program consistent with the terms of the merger agreement.

Halliburton, having accidentally created a valid plan amendment through the language of the merger agreement, was bound to comply with the terms of that plan amendment. Accordingly, Dresser retirees then had the right to enforce their benefits under the ERISA plan.

Although the case does not affect all jurisdictions, it is controlling in the Fifth Circuit (which includes Louisiana, Mississippi, and Texas) and may be cited by other jurisdictions considering similar issues. If your company is located outside of the Fifth Circuit this case serves as a reminder that, under certain circumstances, plans can be inadvertently amended. *Halliburton* offers plan sponsors an important reminder that appropriate care should be taken in structuring any agreements affecting ERISA plans.

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

National Healthcare Spending Slows

As reported in the *Wall Street Journal*, a study by the federal government finds that national healthcare spending nearly reached \$2 trillion in 2005 — an amount equivalent to 16 percent of gross domestic product. This equates to an average spending of \$6,697 per person. The rate of growth from 2004 to 2005 was 6.9 percent, less than the 7.2 percent growth reported for 2004 and, while hefty, it is the lowest rate of increase since 1999.

The average increase burdens federal and state governments at the increased rate of 7.8 percent, while businesses shoulder a 7.0 percent increase, and households paid an average increase of 6.2 percent.

Further putting the brakes on cost are substantially lower increases for prescription drug coverage in Medicaid programs (2.8 percent in 2005). The average overall prescription drug increase came in at 5.8 percent on a national basis. By comparison, the growth in cost of prescription drug coverage was 8.6 percent in 2004 and as high as 18.2 percent in 1999.

Benefiting slow cost growth are the promotion of generic drugs by private insurers and Medicaid plans; more aggressive pursuit of rebates by states, a slowdown in the introduction of newer, more expensive drugs; increased use of mail-order programs, and the withdrawal of big-selling painkillers such as Vioxx. (This study does not reflect the impact of Medicare's prescription drug benefit which was implemented in 2006.)

"It isn't clear whether the deceleration is temporary or part of a longer-term trend," said economist Aaron Catlin, one of the study's authors at the Centers for Medicare and Medicaid Services. The government's full report is being published in the journal *Health Affairs*.

Nondiscrimination Regulations and Wellness Programs

New regulations about HIPAA's nondiscrimination were issued in December addressing health plans' ability to vary premiums and benefits based on participants achieving wellness goals. These regulations become applicable to group health plans starting on the first day of the first plan year that begins after June 30, 2007 (January 1, 2008 for calendar year plans).

Since 1996, HIPAA's nondiscrimination provisions and guidance made it clear that health plans can run afoul of the nondiscrimination standards if they give discounts or rewards to individuals who meet certain wellness goals (e.g., cholesterol below 200 or body mass index below 25). Nonetheless, proposed regulations issued in 2001 allowed an exception for limited plan rewards under wellness programs limited circumstances.

For the most part, the final regulations adopt the proposed regulations' exception intact — but they also include some important clarifications and additional provisions. A comprehensive summary of these rules is beyond the scope of this publication. *Willis Employee Benefits Alert #94* explains how the new nondiscrimination regulations affect wellness programs. Please contact your Willis representative to obtain a copy of our *Alert*.

Department of Labor Announces 2006 Form M-1

According to ERISA, Multiple Employer Welfare Arrangements (MEWAs) that do not qualify for a filing exemption must file a Form M-1 each year. A MEWA is an arrangement that offers welfare benefits to the employees of two or more employers. Complicated rules apply to determine whether two employers are sufficiently related to be considered a single employer, and whether an exception to the filing requirement might apply.

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Early last December the Department of Labor (DOL) issued the 2006 Form M-1. It is substantively identical to the 2005 Form M-1, and retains the electronic filing option that filers are encouraged to utilize. Filers interested in using the online filing process can go to www.askebsa.dol.gov/mewa for additional information.

Filers must comply with the March 1, 2007 filing deadline unless they apply for an extension. A one-time extension until May 1, 2007 will be automatically granted if requested by the MEWA administrator. To make the request, the administrator must complete Parts I and II of Form M-1, sign, date, and print the name of the plan administrator as indicated, and file the request no later than March 1, 2007. A copy of the extension request must be attached to the Form M-1 when it is filed before the extended deadline expires.

Filers may obtain copies of the Form M-1 at the following address: http://www.dol.gov/ebsa/forms_requests.html or may call the Employee Benefits Security Administration (EBSA) at its publication hotline, (866) 444-3272. Questions about the completion of Form M-1 can be directed to EBSA at (202) 693-8360.

IRS: Transition Relief for Payment Cards

The Internal Revenue Service has issued Notice 2007-2 — updated guidance that provides transition relief associated with the use of debit cards for medical expense reimbursements with non-health care related merchant category codes. (For more information about FSAs and debit cards, please see *Willis EB Alert #75*.)

Under the new guidance, these non-health care retailers will be considered as an “other medical care provider” through December 31, 2007. This subtle distinction makes it possible to use the cards to pay for medical expenses at retailers that are not specifically drug stores or pharmacies. These stores will have to qualify by meeting one of the following criteria:

- Participate in the inventory information approval system as described in guidance Notice 2006-69; or
- As measured on a store-location-by-store-location basis, 90 percent of the store’s gross receipts during the previous taxable year consisted of items which qualify as expenses for medical care under tax code Section 213(d).

The guidance also gives substantiation rules for health plan validation of debit card purchases for drug stores and pharmacies as well as “other medical care providers.” After December 31, 2007, the requirement that merchants have the appropriate inventory information approval systems will be enforced. Generally, that means that after 2007 applicable rules will limit FSA debit card usage to pharmacies and drug stores.

Doctors Seek to Sue Blue Cross

The *Los Angeles Times* reports that an already high profile lawsuit is gaining new attention. The California Medical Association, which represents about 30,000 doctors, is joining patients’ class action litigation against Blue Cross. The patients, who hold individual or self-employed insurance policies, claim that Blue Cross routinely approves expensive medical procedures only to drop policyholders and refuse to pay for the treatments.



Regulators continue to investigate the practices of Blue Cross, which is a subsidiary of WellPoint Inc., but the firm contends that it follows current laws and only cancels a small portion of its individual policies. Underwriters note that if crucial information is left off of applications or lied about by applicants, insurance carriers should have the right to drop coverage even after treatments were approved. Health insurance underwriters note that risk management of individual policies differs from that of group insurance policies, which can be used to spread out exposures across larger pools. However, the physicians have claimed that the insurer is obligated under California law to pay for approved treatments regardless of whether policies were canceled.

Laptop Guidance and Electronic PHI

Thefts of laptops and the consumer data they contain have become so ubiquitous that the individual incidents no longer seem newsworthy. Still, the threat is real and must be addressed in advance. Our recommendations to show due diligence in maintaining employees' records in a secure environment include:

- Treat personnel information (like SSNs) as “radioactive” by reviewing all collection, use, storage and destruction of this data.
- Segregate critical data (data required under state laws) from other data.
- Restrict access to critical data and monitor access.
- Encrypt files and databases containing critical data.
- Create or strengthen policies of handling personal information.
- Screen, train, and hold accountable all employees with access to personal information.
- Review data-handling practices and safeguards with third parties.
- Develop a data-breach contingency plan.

Numerous security incidents, particularly the loss of laptops, have now led the Department of Health and Human Services (HHS) to formally issue guidance addressing the protection of electronic protected health information (PHI) that is stored or accessed outside of a covered entity's physical control. HIPAA-covered entities (including employer sponsored group health plans) should allow offsite use or access to PHI only when “clearly determined necessary” and only if applicable policies, procedures and workforce training to reduce the risk of loss have been effectively adopted.

Workforce training should cover the fundamental problems associated with remote access to electronic PHI. Such training should also include clear instructions for accessing, storing, and transmitting electronic PHI. HHS also suggests specific policies to bolster safety such as policies that prohibit leaving devices in unattended cars.

The actual guidance is plainly an application and reiteration of obligations already set forth as part of the original HIPAA privacy regulations. Many of the steps already included in our client recommendations are endorsed by the HHS in this new guidance.

Any time electronic PHI is carried away, accessed offsite, or downloaded, there is a risk of inappropriate access or loss. Plans subject to the HIPAA rules of the need to revisit their training programs as well as to create policies and procedures featuring meaningful plans to minimize the damage associated with any privacy breakdowns.

Congress Eager for Part D Enrollment Numbers

The legislative tracking publication *The Hill* reports that Medicare Part D is once again a hot topic in Congress. The most recent sign-up window for Medicare Part D prescription-drug coverage concluded on December 31. The Bush administration and others are waiting to find out if people are participating in plans that best meet their needs. The aim during the program's second year was to persuade elderly and disabled enrollees to reconsider their plans, which changed in many cases. Legislators, the Centers for Medicare and Medicaid Services, health-sector members, and beneficiaries' activities mostly forecast that the majority of individuals signed up for Part D would stay with the coverage they chose in the first enrollment period, which ran from November 2005 to May 2006.

Most opinion surveys performed last year suggested that the majority of Part D participants were satisfied (or more than satisfied) with their drug coverage — in spite of general complaints about program complexity. The private insurers that offer the drug coverage made many changes to their plans for 2007, including altering premiums, deductibles, cost-sharing duties, and the pharmaceuticals they cover. In addition, the Bush administration reduced its education and outreach initiatives for the second new year's enrollment period. In spite of this, the administration has voiced confidence that participants will be proven to have been prudent shoppers during the sign-up period.

California's Proposed Health Care Reform

California Governor Arnold Schwarzenegger (R) has a plan intended to "reduce the hidden tax, lower costs, support better care and create a healthier Californian." According to a press release accompanying the governor's announcement, the three essential plan elements are:

1. Prevention, health promotion and wellness
2. Coverage for all Californians
3. Affordability and cost containment

Proposal Highlights

- All Californians will be required to have health insurance coverage.
- Insurers will be required to guarantee coverage.
- Wellness programs will be implemented in the private and public sectors.
- Low-income Californians will be provided with expanded access to public programs and working residents will be provided with financial assistance to help with the cost of coverage through a state-administered purchasing pool.
- Medi-Cal rates will be increased significantly.
- Insurer and hospital efficiency will be improved by requiring them to spend 85 percent of every premium dollar on patient care.
- State tax laws will be aligned with federal laws to allow people to make pre-tax contributions to Health Savings Accounts. Employers will also be required to establish Section 125 plans.
- Doctors will be assessed a two percent coverage dividend, and hospitals will be assessed four percent, to help cover the increased Medi-Cal rates. Employers of 10 or more employees who do not provide employee coverage will contribute four percent of payroll.

Details of the governor's plan can be found at <http://gov.ca.gov/index.php?/press-release/5057/>.

Wal-Mart: FSA Debit Card Technology Leader

Wal-Mart is set to roll-out new technology for consumers who use flexible spending account debit cards to pay for health care merchandise. The new Wal-Mart technology identifies merchandise that is eligible to be purchased with an FSA debit card as items are scanned at checkout. After all the items have been scanned, the system will display a total for the transaction showing FSA and non-FSA merchandise. If the consumer wants to use an FSA debit card for payment of eligible merchandise, he or she can swipe the card at the debit card reader.

According to the director of third-party administration for Wal-Mart Pharmacy, the introduction of the new technology means that consumers will no longer be forced to guess about which items are eligible for FSA card payment.

Since You Asked: COBRA and Medicaid

COBRA does not require employers to provide continuation coverage after a beneficiary becomes entitled to Medicare or covered under any other *group health plan* which does not limit or exclude any pre-existing condition. We were recently asked if, under this rule, may an employer terminate COBRA coverage upon enrollment in Medicaid.

We believe that the short answer is “no.”

Long Answer

COBRA rules state that Medicare includes only benefits under Title XVIII of the Social Security Act. Medicaid is provided under Title XIX of the Social Security Act. So, the “entitled to Medicare” aspect of the rule will not allow termination of COBRA coverage upon enrollment in Medicaid.

For the other aspect of the rule to apply, a qualified beneficiary must become covered under “another group health plan.” IRS regulations define a group health plan, in part, as a “plan maintained by an employer or employee organization [for] individuals who have an employment-related connection to the employer or employee organization.” Medicaid is not maintained by an employer for its employees and so, it does not qualify as a group health plan for this purpose.

Medicaid should not be considered other coverage, and COBRA coverage should not be terminated due to Medicaid enrollment. In some instances states will pay COBRA premiums rather than provide Medicaid benefits directly because it is more cost effective.

U.S. Benefit Office Locations

Atlanta, GA
(404) 224-5000

Boston, MA
(617) 437-6900

Cleveland, OH
(216) 861-9100

Detroit, MI
(248) 735-7580

Ft. Worth, TX
(817) 335-2115

Jacksonville, FL
(904) 355-4600

Los Angeles, CA
(213) 607-6300

Miami, FL
(305) 373-8460

Naples, FL
(239) 514-2542

Omaha, NE
(402) 778-4851

Phoenix, AZ
(602) 787-6000

St. Louis, MO
(314) 721-8400

San Juan, PR
(787) 756-5880

Wilmington, DE
(302) 477-9640

Austin, TX
(800) 861-9851

Cary, NC
(919) 459-3000

Columbus, OH
(614) 766-8900

Eugene, OR
(541) 687-2222

Grand Rapids, MI
(616) 954-7829

Knoxville, TN
(865) 588-8101

Louisville, KY
(502) 499-1891

Milwaukee, WI
(414) 271-9800

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(615) 872-3700

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(949) 885-1200

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(412) 586-1400

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Seattle, WA
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Baltimore, MD
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