

# WELLNESS

## TOP 5 MYTHS ABOUT RETURN ON INVESTMENT FOR WORKSITE WELLNESS PROGRAMS

1. Worksite wellness programs aren't worth the effort - unless there is a measurable ROI.
2. ROI data should be available soon after any wellness activity or program is completed.
3. If one wellness program achieves a positive ROI, so can yours - if the same activities or program are implemented.
4. ROI can be "guaranteed."
5. Most employers are calculating a ROI.

### 1. WORKSITE WELLNESS PROGRAMS AREN'T WORTH THE EFFORT - UNLESS THERE IS A MEASURABLE ROI.

**Show me the money!** Don't become so focused on researching case studies and finding convincing ROI data that you neglect to research the internal resources and challenges of your own organization. Program components that worked for a large, national employer may not work for your mid-sized, local business. Some best practices do translate into almost any program; however, it is important to recognize that no specific wellness program design can be universally applied to achieve a ROI. The value of investing in worksite wellness is often best captured through health risk reductions, increasing program engagement, program satisfaction and individual employee success stories. Often, a wellness program can even be viewed as an additional benefit or "perk" by employees and can contribute to talent attraction and retention.



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## 2. ROI DATA SHOULD BE AVAILABLE SOON AFTER ANY WELLNESS ACTIVITY OR PROGRAM IS COMPLETED.

**Where's my ROI?** What is the ROI for a health fair? Offering a fitness center discount? Conducting on-site biometric screenings? An employer is unlikely to calculate a true ROI on any single activity in the short term. In the long term, however, the cumulative effect of a multi-component program can be determined. Your wellness program provider should be providing reports on participation, satisfaction and, most importantly, program outcomes that showcase health improvement and behavior change. These are the outcome reports you should be demanding from the very beginning of your program. Keep in mind that you will need at least two years of comparable data from your vendor in order to start assessing your program's overall impact.

The value of investing in worksite wellness is often best captured through health risk reductions, increasing program engagement, program satisfaction and individual employee success stories. Often, a wellness program can even be viewed as an additional benefit or "perk" by employees and can contribute to talent attraction and retention.

## 3. IF ONE WELLNESS PROGRAM ACHIEVES A POSITIVE ROI, SO CAN YOURS - IF THE SAME ACTIVITIES OR PROGRAM ARE IMPLEMENTED.

**It worked for them, let's do the same thing!** Trying to replicate someone else's wellness program to achieve a positive ROI is challenging and ultimately pointless. The specific group in the study or article whose program you are trying to replicate would have to be in the same industry and demographic, use the same vendor, have similar leadership tactics and similar communication methods as your own organization in order to effectively translate. To further complicate matters, a true, more robust return on investment calculation takes into account such factors as the financial impact of health care trends, inflation, plan design changes and various biases (e.g., healthier people tend to participate in wellness [selection bias]) that are nearly impossible to account for at most worksites. The truth is that the typical worksite wellness environment is not an ideal setting for rigorous, randomized research studies that show a ROI calculation so a more realistic approach is needed to evaluate success.

## 4. ROI CAN BE GUARANTEED.

**"We guarantee it!"** Can a wellness vendor guarantee a ROI for their program offerings? Many seem to indicate that they can. But, remember, many important factors that strongly influence the potential for ROI are in the hands of the employer – not the vendor. One such factor is program participation. It is often hard to define and predict what the program participation will be before a program has begun, which makes predicting or guaranteeing ROI a risky endeavor. Making an investment in the most expensive, best-in-class wellness program may not guarantee success for you because of the major influence of management support, a healthy worksite culture and a dynamic communication campaign that is uniquely designed to engage your unique employees – all of which are dependent on your internal investment and focus throughout the program.

## 5. MOST EMPLOYERS ARE CALCULATING ROI.

### Everyone else is doing it or talking about it, why aren't you?

Don't be discouraged. The reality is many employers are not calculating ROI and may never have the resources or comprehensive program dynamics to do so. A validated ROI involves calculating the net benefits (or savings minus program costs) as compared to the cost of the original investment. Many worksite wellness articles and presentations cite the typical "3:1" ROI that can be achieved.

Many people may not realize that the true process of calculating ROI involves complex data requirements and analytical or actuarial evaluation. Many published research studies on ROI have collaborated with, and paid for, expert assistance to collect and analyze the necessary data from sources such as health risk assessments, medical claims and absenteeism. This type of data needs to be collected into a trusted data warehouse and analyzed over time. Many employers struggle with issues such as collecting participation data, not having a large enough participant group to make comparisons over time and not being able to collect consistent data from the same vendor year after year.

Another common way that employers are looking at ROI is by doing what is called a "cohort analysis." This refers to the comparison of the same group (cohort group) of health risk assessment participants year over year. Reduction in health risks and improvements in scores are variables that can be assigned a dollar value, which translates into savings, or cost avoidance. Studies conducted at the University of Michigan Health Management Research Center and by the Health Enhancement Research Organization (HERO) are often used as sources for the financial offset figures.

## SUMMARY

Most worksite health promotion programs are put in place intending to generate cost savings but are often not planned nor built to produce optimal results. In order to achieve a positive ROI, a comprehensive program should be customized to meet your unique needs and culture. Realistically, you may be able to *estimate* ROI and demonstrate health improvement. Avoid focusing too heavily on "ROI" or throwing around that term when discussing the potential impact of worksite wellness programs. Instead focus your efforts on building the best program you can that is customized to your needs and commit to working with vendors that can effectively showcase the value of your program in realistic ways in the short and long term. To learn more about customizing your wellness program design, please contact your Willis Service Team.

# HR CORNER

## FOR FMLA, HOW MANY HOOPS TO JUMP THROUGH?

A Texas hospital required its employees to contact its third-party administrator about FMLA requests within two days. If leave was intermittent, the administrator had to be contacted every time. One employee, having used intermittent leave repeatedly, had a psychiatric crisis and didn't contact the administrator within the two-day window. Should she have been terminated for that failure?

### WHAT HAPPENED

"Stiles," a patient care partner at Harlingen Medical Center, had suffered from partial complex epileptic seizures since June 2006, and she took intermittent leave nine times between mid- and late- 2006. In late December, she had a psychiatric episode involving bipolar disorder and depression. Her mother notified Harlingen that Stiles was being admitted to the emergency room on December 29, where one of her supervisors visited her. She was then moved to a psychiatric facility, with her supervisors frequently reminding her mother that Stiles needed to contact the plan administrator as soon as possible.

She finally did so after her release, on January 9 – but since she had not complied within two days, Harlingen fired her. She sued for violation of her rights under the Family and Medical Leave Act (FMLA). A federal district court judge ruled in favor of the hospital, reasoning that Stiles forfeited her rights to FMLA when she failed to contact the administrator by January 2. The judge stressed that she should have known what to do, since she'd done it nine times in the previous weeks. Stiles appealed to the 5th Circuit, which covers Louisiana, Mississippi, and Texas.

### WHAT THE COURT SAID

The district judge had compared Stiles's case to one the 5th Circuit decided in 2007. But in

that case, the employee refused to complete FMLA paperwork, and the employer didn't know what medical condition created the need for leave. That was not the case with Stiles, judges said; the hospital was fully informed about her condition at every step of the way and had plenty of notice at all times.

So managers were not permitted to overlay their own heightened notice requirement on the information Stiles and her mother had already provided. "The FMLA requires only that an employee contact her employer and state that leave is needed as soon as practicable under the facts and circumstances of the particular case," judges wrote. *Saenz v. Harlingen Medical Center*, U.S. Court of Appeals for the 5th Circuit, No. 09-40887 (2010).

### POINT TO REMEMBER

Employees need not even refer directly to FMLA – much less follow an employer's particular notice requirement – when requesting leave, as long as they clearly indicate the need and the reason for it, including medical certification.

*This article provided by BLR.*

## CAN YOU BAN POLITICAL DISCUSSION IN THE WORKPLACE?

Private employers may ponder the wisdom of allowing political discussions at the water cooler or from cubicle to cubicle. Generally, employers choose not to prohibit all conversations simply because enforcing such a ban is difficult, if next to impossible.

So, if talking politics interferes with work or become disruptive, employers probably will need to ban work-time political discussions. For example, if an employee engages other employees in a debate and tries to persuade them to vote for a particular candidate, this would likely interfere with work.

Some employees will be relieved by the policy, because they do not want to be forced into political discussions or fear that if they don't agree, it will jeopardize their workplace relationships. Other employees may see heated political discussion as harassment, so it is best for the employer to put an end to it.

Yet experts believe that HR should not create a policy banning all political conversations – it can seem draconian. Instead, they advise including a segment in ongoing training for supervisors on the potentially disastrous consequences of unfettered political discussion. That way, employees who are sure of their audience can talk all they want, while others tread lightly around the topic.

*This article provided by BLR.*

# LEGAL & COMPLIANCE

## MERPS – HOW WILL HEALTH CARE REFORM AFFECT THEM?

In the last few weeks, Willis' National Legal & Research Group (NLRG) has been asked several questions regarding medical expense reimbursement plans (sometimes referred to as MERPs) for key executives. The concern is inspired by a provision in the Patient Protection and Affordable Care Act (PPACA) that prohibits an insured plan from discriminating on the basis of compensation. This article describes some of the methods that might be considered for 2011 to avoid the application of PPACA's nondiscrimination requirement to insured plans.

### BACKGROUND

Many industries forced employers to use their medical benefits program to compete for certain key executives in a way that resulted in "highly compensated employees" (HCEs) being provided with enhanced medical benefits more generous than those of rank-and-file employees. These plans were not allowed to discriminate in favor of the HCEs (essentially the top 25% most highly compensated employees of the companies) if the plans were self-funded. In the event a self-funded medical benefits plan does discriminate in favor of HCEs, then pursuant to § 105(h) of the Internal Revenue Code (IRC), the benefits paid under the plan (not the premium or premium equivalent, but the actual medical reimbursements) would be taxable to the HCE on whose behalf the benefits are paid.

To avoid the unpleasant tax result, many employers adopted insured plans to pay those benefits as insured plans were not subject to the nondiscrimination rules of § 105(h). However, that planning was specifically undercut by the provision of PPACA that provides that insured medical benefits cannot discriminate on the basis of compensation (but specifically excluded self-funded plans and those that are excluded from HIPAA compliance). Given PPACA's \$100/day penalty for each violation of its nondiscrimination rule, employers have asked what they can do, if anything, to avoid that issue.

### POSSIBLE ALTERNATIVES

#### MAINTAIN GRANDFATHER STATUS FOR THE DISCRIMINATORY PLAN

As the nondiscrimination provision under PPACA does not apply to grandfathered plans, one option for these plans is to keep them grandfathered. While it would likely be very difficult to maintain grandfathered *status for the underlying medical plan, the smaller MERP might be able to maintain that status more easily* (particularly since there is rarely any cost sharing under the MERPs since that is precisely what they are designed to avoid). Under the grandfather plan Interim Final Regulation (IFR), each benefits package is analyzed separately to determine its grandfathered status. If the MERP is a separate plan with a separate document, SPD and 5500 filing (which admittedly is unlikely) that should be an easy determination. However, even if the MERP is more integrated into the underlying plan, it should still, in most cases, be distinguishable from the underlying plan and be treated as a separate benefits package for purposes of the grandfather plan status rules. For additional information regarding grandfathered plan rules, see Willis Human Capital Practice, Vol. 3, No. 12, "**Regulations on Grandfathered Plans.**"

## DETERMINE IF THE MERP IS A HIPAA-EXCEPTED PLAN

PPACA provides that plans that are excepted from the application of HIPAA are not subject to the PPACA requirements. One type of HIPAA-excepted plan is a purely supplemental plan designed to fill in the gaps of the underlying medical plan (in the same way a Medicare supplemental policy is intended to do). Taken literally, that would mean that many MERPs would be excepted from all the PPACA provisions, including the nondiscrimination provision. It is not clear that was the intended effect of those provisions, so employers should take the proper cautions, including obtaining the appropriate legal advice, before relying on this exception. For additional information about supplemental plans and the HIPAA exception, please see Willis Human Capital Practice Alert, No. 123, “**DOL Closes a Loophole in Requirements for Wellness Programs.**”

## ADOPT A HDHP AND PROVIDE AN HSA FOR THE AFFECTED HCES

A different twist on plan design might be for the employer to adopt a high deductible health plan (HDHP) that meets the rules for HDHPs permitting an employee to maintain and fund a health savings account (HSA) under Section 223 of the IRC. That would enable the HCEs to fully fund their own HSAs with tax-deductible funds. By funding their own HSAs, they would essentially get the main part of the benefit of the MERP and it would be fully tax-deductible. Moreover, in some ways it would be more valuable than a MERP because, if the funds are not used for current qualified medical expenses, they are 100% vested and portable and the employees fully own and control the accounts. Note that the HDHP would generally be open to all employees (or at least would not discriminate on the basis of compensation) and all participants would be eligible to fund their HSAs. If the employer were to fund the HSAs, it would have to do so on a nondiscriminatory basis making comparable contributions to all the HSA accounts of its employees (unless employer HSA contributions are made through the employer's cafeteria plan, in which case those nondiscrimination rules would apply). However, it would be possible for the employer to give certain favored employees, such as the HCEs, additional compensation

that would be taxable to those HCEs. If the HCEs had the option to contribute to their HSAs or keep the additional income as taxable income, then they could make their own determination as to the value of the MERP (or in this case the HSA). However, the employer would not be able to direct the contributions if it wished to avoid negative tax implications for the affected employees.

## CONCLUSION


While PPACA put a crimp into the MERPs, there are still some planning possibilities available to employers for whom the MERPs have an important role.

## HHS ANNOUNCES CHANGES TO OPT-OUT ELECTION FOR SELF-FUNDED NONFEDERAL GOVERNMENTAL PLANS

In a recent **memo**, HHS explained the current status of the opt-out provision for certain group health plan mandates available to self-funded nonfederal governmental plans. Prior to the enactment of the Patient Protection and Affordable Care Act (PPACA), plan sponsors of self-funded nonfederal governmental plans could elect to opt out of certain provisions of Title XXVII of the Public Health Service Act (PHSA). These provisions included:

- Limitations on preexisting condition exclusion periods
- Requirements for special enrollment periods
- Prohibitions against discriminating against individual participants and beneficiaries based on health status (but not including provisions added by the Genetic Information Nondiscrimination Act of 2008 (GINA))
- Standards relating to benefits for newborns and mothers (Newborns' and Mothers' Health Protection Act)
- Parity in the application of certain limits to mental health and substance use disorder benefits (including requirements of the Mental Health Parity and Addiction Equity Act [MHPAEA])
- Required coverage for reconstructive surgery following mastectomies (Women's Health and Cancer Rights Act)
- Coverage of dependent students on a medically necessary leave of absence (Michelle's Law)

Following the enactment of PPACA, however, plan sponsors of self-funded nonfederal government plans may no longer opt out of HIPAA's portability requirements (the first three items listed above). Once the changes under PPACA become effective



(see the discussion regarding the effective date below), sponsors will only be able to opt out of the following group health plan mandates:

- Standards relating to benefits for newborns and mothers (Newborns' and Mothers' Health Protection Act)
- Parity in the application of certain limits to mental health and substance use disorder benefits (including requirements of the Mental Health Parity and Addiction Equity Act [MHPAEA])
- Required coverage for reconstructive surgery following mastectomies (Women's Health and Cancer Rights Act)
- Coverage of dependent students on a medically necessary leave of absence (Michelle's Law)

The memo is clear that the opt-out election is not subject to the grandfathering provision. This means that even if a self-funded, nonfederal governmental plan is a grandfathered plan, it will no longer be able to opt out of the HIPAA portability requirements.

## EFFECTIVE DATE

For plans that are not subject to a collective bargaining agreement, the change is effective for plan years beginning on or after September 23, 2010.

**EXAMPLE** A nonfederal governmental employer has elected to exempt its self-funded group health plan from all seven requirement categories, as permitted prior to the enactment of PPACA. The plan year begins September 1. The plan may continue to be exempted from all seven requirement categories for the plan year that begins on September 1, 2010. However, beginning with the plan year that commences on September 1, 2011, the plan can no longer be exempted from the following requirements: limitations on preexisting condition exclusion periods, special enrollment periods, and the prohibitions against discriminating against individual participants and beneficiaries based on health status. Accordingly, for that plan year and any subsequent plan years, the plan sponsor may elect to exempt its plan only from any or all of the remaining four requirement categories (regardless of whether the plan is a grandfathered plan or not).

For plans maintained pursuant to a collective bargaining agreement, the PHSA provides that an opt-out election made pursuant to a collective bargaining agreement remains in effect "for the term of such agreement." This rule was not amended by PPACA. As such, a group health plan that is maintained pursuant to a collective bargaining agreement ratified before March 23, 2010, and that has been exempted from the limitations on preexisting condition exclusion periods, the requirements for special enrollment periods or the prohibitions against discriminating against individual participants and beneficiaries based on health status, will not have to come into compliance with those provisions until the commencement of the first plan year following the expiration of the last plan year governed by the collective bargaining agreement.

**EXAMPLE** A nonfederal governmental employer elected to exempt its collectively bargained self-funded plan from all seven requirement categories. The collective bargaining agreement applies to three plan years, October 1, 2009 through September 30, 2012. For the plan year that commences on October 1, 2012, the plan sponsor is no longer permitted to elect to exempt its plan from the following provisions: limitations on preexisting condition exclusion periods, special enrollment periods, and the prohibitions against discriminating against individual participants and beneficiaries based on health status. Accordingly, for that plan year and any subsequent plan years, the plan sponsor may elect to exempt its plan only from any or all of the remaining four requirement categories.

## NON-ENFORCEMENT POLICY

Given the confusion regarding the status of the opt-out provision following the enactment of PPACA, official guidance from HHS is welcome news for those plan sponsors able to take advantage of it. While sponsors will no longer be able to opt out of the HIPAA portability requirements, the ability to continue to opt out of the other group health mandates, particularly the requirements under MHPAEA, is important (both financially and administratively) for employers currently opting out of those provisions.

Given the timing of this guidance, HHS indicates that it will not take any enforcement actions with respect to opt-out elections for plan years beginning prior to April 1, 2011 on the following provisions: limitations on preexisting condition exclusion periods, special enrollment periods, and the prohibitions against discriminating against individual participants and beneficiaries based on health status.

## NEW GUIDANCE ON AGE 26 MANDATE AND OTHER TOPICS

The Department of Labor (DOL) has posted several new items regarding implementation of some health care reform law provisions that are effective for plan years starting September 23, 2010 or later. Most of the items involve technical details that will not greatly affect employers' immediate implementation efforts. A few items are noteworthy, however.

### DEFINITION OF DEPENDENT CHILD

Many employers are struggling with implementation of the provision that disallows having a limiting age for dependent children lower than age 26 (for details of this mandate, see Willis Human Capital Practice *Alert*, Vol. 3, No. 8, "**Adult Children Health Coverage Extension: Regulations Published**"). The new items include **FAQs**, and one of them states that plans may impose eligibility conditions in addition to being under age 26 (such as residing with the employee or being financially dependent on the employee) with respect to children who are not within the Internal Revenue Code's definition of child. Here is the relevant passage from the FAQ:

A plan or issuer does not fail to satisfy the requirements of PHS Act section 2714 [the age 26 mandate] or its implementing regulations because the plan limits health coverage for children until the child turns 26 to only those children who are described in section 152(f)(1) of the Code. For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

This guidance will be a relief for many employers because, under the agencies' (the Departments of Labor, Treasury and Health and Human Services) regulations, plans cannot condition plan dependent child eligibility on anything other than age and the "relationship" between the participant and the child, meaning that eligibility of dependent children cannot be conditioned on:

- Financial dependence
- Residence
- Student status
- Marital status
- Employment
- Other similar factors

For employers that previously defined dependent child eligibility broadly so that an employee could cover children who lived with or were supported by the employee regardless of legal relationship, this provision meant that they could no longer use the very factors previously used to determine whether a child was sufficiently related to an employee to be considered the employee's child. With permissible eligibility conditions being limited to age and relationship, employers that had previously defined dependent broadly found themselves eliminating eligibility for some children.

Under the FAQ guidance, use of the non-relationship factors noted above is permitted for children who are not within the tax code's definition of child (generally, a "son, daughter, step-child, adopted child, or eligible foster child"). For children who are within that definition, however, the only permitted eligibility conditions are relationship to the employee and age. Note that nothing requires a plan to cover all children within the tax code definition, so that a plan may exclude all step-children from coverage, for example, but cannot allow coverage of some step-children and not others based on residence with the employee.

This guidance harmonizes the scope of the mandate with another provision of the health care reform law, under which health coverage provided to any "child" is tax-free to the employee until the end of the calendar year in which the child turns 26, even if the child is not otherwise the employee's dependent. For

information on the tax exclusion and a more detailed explanation of the tax code definition of child, see Willis Human Capital Practice *Alert*, Vol. 3, No. 6, "**IRS Guidance Regarding Tax-Free Health Coverage for Adult Children.**"

## CLARIFICATION OF EXTERNAL REVIEW CONTRACTING REQUIREMENTS

Implementing external review processes required by the health care reform law initially was not a large concern for most employers. First, the requirements for internal claim and appeal procedures and external review processes apply only to non-grandfathered plans. Second, it was generally assumed that compliance with the external review requirement would be a function that insurers and third-party administrators (TPA) would perform on behalf of employer-sponsored plans. Regulations issued July 22 generally confirmed this assumption for insured plans' external review obligations and, for self-insured plans, additional guidance on the external review requirements was promised. That guidance, issued on August 23, did not ensure that the sponsor of a self-insured plan could delegate the external review function to a TPA. In fact, many read the August 23 guidance as requiring some employers to be directly involved in creating an external review process for their self-insured plans.

One way to meet the external review standards set out in the August 23 guidance is to contract with three independent review organizations (IROs) and refer qualifying review requests to those IROs in rotation. The August 23 guidance indicated that a plan would have to enter into contracts that meet exacting requirements with the three IROs, raising issues about whether the contracts must be negotiated and entered into by a plan fiduciary with authority to bind the plan (i.e., by the employer, in most cases). The new FAQ guidance confirms that the August 23 guidance "does not require a plan to contract directly with any IRO. Where a self-insured plan contracts with a TPA that, in turn, contracts with an IRO, the standards of the [August 23 guidance] can be satisfied in the same manner as if the plan had contracted directly." The new FAQ guidance provides, however, that an employer who delegates creation of its self-insured plan's external review process to the TPA is still ultimately responsible for ensuring compliance with the external review requirement.

## REGULATORY GRACE PERIOD FOR SOME NEW INTERNAL CLAIM PROCESSING REQUIREMENTS

Also of interest to employers is a regulatory grace period announced for some of the new requirements relating to internal claim and appeal procedures. These new internal claim and appeal requirements – as well as the external review

requirements noted above – apply to non-grandfathered plans only. Under regulations that the agencies issued July 22, in addition to complying with the DOL's existing requirements for claim and appeal procedures, plans were required to comply with seven additional requirements for their internal claim and appeal procedures. The agencies have now issued a **temporary non-enforcement policy** with respect to four of these new requirements. Until July 1, 2011, the agencies will not enforce the following new requirements against a plan “that is working in good faith to implement such additional standards but does not yet have them in place.”

- Notifying a claimant of an initial decision on an urgent pre-service claim within 24 hours after the receipt of the claim (as opposed to 72 hours, required under current rules)
- Providing notices in an alternate language as provided in the regulations
- Including additional information in certain notices to claimants (e.g., the date of the service, the health care provider and the claim amount (if applicable), as well as the diagnosis code, the treatment code and the denial code along with the meaning of those codes)
- Strictly adhering to all the requirements of the interim final regulations regarding internal claim and appeal procedures

In connection with the shortened time to decide urgent pre-service claims, the agencies also have issued a **Revised Model Notice of Adverse Benefit Determination**, replacing the earlier version issued on August 23. The replacement is intended to eliminate confusion regarding the application of shortened timeframes for initial determinations with respect to urgent claims.

Unfortunately, the regulatory grace period does not extend to all of the requirements, and non-grandfathered

plans must begin complying with the following requirements with their next plan year:

- Rescission of coverage must be treated as a claim subject to the plan's claim and appeal procedures
- Requirements to provide the claimant (automatically, as soon as possible, free of charge, and sufficiently in advance to allow response) with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial
- Prohibition against making decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual (such as a claim adjudicator or medical expert) based upon the likelihood that the individual will support a denial of benefits

## AGENCIES' APPROACH TO ENFORCEMENT

The DOL's FAQs also state that the agencies' approach to implementation “is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices.”

## IRS ISSUES GUIDANCE: REIMBURSEMENT OF OTC MEDICINE FROM ACCOUNT-BASED PLANS

One significant change under the Patient Protection and Affordable Care Act (PPACA) was to limit reimbursements from account-based plans for over-the-counter (OTC) medications. Under existing law, FSAs, HRAs, HSAs and MSAs are generally permitted to pay or reimburse on a tax-free basis all OTC medicine and drugs. The PPACA, however, included certain statutory changes to the Internal Revenue Code (IRC) such that employer plans will no longer be permitted to reimburse expenses for OTC medicines or drugs unless a prescription is obtained. There is an exception to this rule for insulin (which can be purchased and reimbursed without a prescription). PPACA left unanswered questions about how these changes would be administered, and recent regulations provided some clarity.

The Internal Revenue Service (IRS) issued two items of guidance, **IRS Notice 2010-59** and **Revenue Ruling 2010-33**, on September 3, 2010. The Revenue Ruling changes the tax treatment of OTC medication reimbursement in accordance with PPACA, and the Notice revises the definition of “medical expenses” for employer-

provided accident and health plans, including health flexible spending accounts (health FSAs) and health reimbursement arrangements (HRAs) as it relates to reimbursement of OTC drugs and medicines. The guidance also revises the definition of “qualified medical expenses” of OTC drugs and medicines as it relates to distributions from Health Savings Accounts (HSAs) and Archer Medical Savings Accounts (Archer MSAs). Note: Distributions from an HSA or Archer MSA that are for nonqualified medical expenses will be subject to a 20% additional tax. This is an increase of 10% as of January 1, 2011.

The effective date of this PPACA provision is January 1, 2011. With 2011 rapidly approaching, many employers have been anxiously awaiting guidance regarding the OTC reimbursement prohibition. Thus, the following additional important clarifications that the Notice provides are helpful.

- A prescription is defined as a written or electronic order for a medicine or drug which meets the legal requirements of a prescription in the state in which the medical expense is incurred. Further, a prescription is issued by an individual legally authorized to issue prescriptions.
- The January 1, 2011 effective date is applicable regardless of whether the employer’s plan is a fiscal or calendar year, and regardless of any applicable grace period for a health FSA. Note: This is different from most PPACA provisions, which are effective on the first day of the first plan year on or after September 23, 2010.
- Reimbursements for OTC medicine and drug expenses incurred on or after January 1, 2011 are prohibited, even if funds were set aside in 2010.
- The prohibition on the reimbursement of OTC expenses is not applicable to those items that are not medicines or drugs, including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits. Therefore, items which continue to meet the definition of “medical care” (which includes expenses for the diagnosis, cure, mitigation, treatment or prevention of disease) may still qualify as being reimbursable.

Many employers have implemented the use of debit cards for reimbursement of OTC expenses and may wonder exactly how their use will be affected by this prohibition of OTC expense reimbursement. The Notice also provides some rules regarding debit card usage. A summary of those requirements follows:

- The IRS will not challenge the use of health FSA and HRA debit cards for expenses incurred through January 15, 2011. This limited relief acknowledges that under the new rule, debit card systems will probably be incapable of complying with the substantiation requirement of debit card usage.
- Medical expenses other than OTC medicines or drugs can continue to be reimbursed through a debit card.
- Debit cards may continue to be used at pharmacies that do not have a qualifying Inventory Information Approval System, as long as the store satisfies the requirement that 90% of its gross receipts were for medical care expenses and substantiation is properly submitted.

For additional information on the rules regarding the use of debit cards, please see Chapter 3 of the Willis Online Compliance Manual. Willis clients can contact their local Willis representative for access to the Compliance Manual.

Finally, the Notice provides a transition rule for cafeteria plan amendments as it relates to retroactive amendments. Although retroactive amendments are generally prohibited, a retroactive amendment to conform to the requirements set forth in the Notice, adopted by an employer’s cafeteria plan no later than June 30, 2011, is permissible.

The clarifications and guidance provided by the IRS Notice is welcome news to employers who sponsor account-based plans, as January 1, 2011 is just around the corner.

Beginning in the 2010 tax year, an eligible small employer may claim a tax credit of up to 35% for premiums it pays toward health coverage for its employee. This credit is generally available to for-profit and non-profit eligible small employers with fewer than 25 full-time equivalent employees as long as the average annual compensation of these employees is not greater than \$50,000. The credit is available through 2013. The draft Form 8941 that is currently available is only an advance proof copy; the final version of Form 8941 will be made available later this year. Information about the small employer tax credit can be found in Willis' Human Capital Practice *Alert* Vol. 3, No. 5 "**Health Care Reform: Impact on Small Employers.**"

## DRAFT FORM FOR SMALL EMPLOYER TAX CREDIT RELEASED

The IRS **announced** the release of a draft version of the new Form 8941, "Credit for Small Employer Health Insurance Premiums." This form will be used by small businesses to calculate the health care tax credit provided under the Patient Protection and Affordable Care Act (PPACA). A small business will include the amount of the credit as part of the general business credit on Form 3800. A tax-exempt organization, however, will claim the credit on Form 990-T. This form is currently used by tax-exempt organizations to report and pay tax on unrelated business income.

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## TIME AGAIN...TO IMPUTE INCOME ON GROUP TERM LIFE INSURANCE

If an employee has more than \$50,000 in group term life insurance coverage through his or her employer, the excess coverage may be taxable under federal law. If it is, federal law also requires the employer to impute income to the employee. Some employers satisfy the requirement by imputing income on life insurance coverage as it is provided during the year. Others wait until the end of the year. Both methods are permitted as long as imputing is completed by the end of the year.

### BACKGROUND

The federal tax code excludes the cost of the first \$50,000 in group term life insurance coverage that an employer provides to an employee. Because there is no tax code exclusion for additional employer-provided coverage, the cost of excess coverage is subject to federal income and FICA (Social Security and Medicare) taxes. The employer providing the excess coverage must report the cost of it on the employee's W-2 and must withhold the employee's portion of FICA taxes and pay the employer's portion.

**NOTE:** The imputing requirement may be avoided in some cases if the premium rates under the group term life insurance policy(ies) meet certain requirements. This design strategy is discussed in Chapter Eight of the Willis Online Compliance Manual, but is beyond the scope of this article. (Editor’s Note: Please contact your Willis adviser should you need to obtain access to a document in this manual.)

## EMPLOYEE PAYS, BUT EMPLOYER PROVIDES

If an employee pays the entire premium for life insurance, one might assume that the coverage is not employer-provided. For group term life insurance, however, that is not always the case. First, if the employee pays for coverage using pre-tax dollars, the coverage is treated, for tax purposes, as if the employer paid those premiums. Second, even if the employee pays the entire premium on an after-tax basis, the coverage may be considered partly employer-provided. That can happen when the cost of coverage for tax purposes is higher than the premium that an insurer charges.

## IRS DETERMINES THE “COST” OF GROUP TERM LIFE INSURANCE

IRS regulations include a table of rates (reproduced below) for calculating the cost of excess group term life insurance for tax purposes. The Table I rates are not indexed for inflation, so they do not change each year – the rates are the same for 2010 as they were for 2009 and will not change until the regulations are revised.

**TABLE I RATES FOR GROUP TERM LIFE INSURANCE**

MONTHLY COST/ \$1,000 OF COVERAGE	
AGE BRACKET*	RATES
Under 25	\$0.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.66
65-69	1.27
70 and over	2.06

*\*When imputing income for 2010, use the employee’s age on December 31, 2010.*

Of course, the IRS-determined rates may be higher or lower than the premiums actually paid for group term life insurance coverage. If the IRS rates are higher, an employee who paid 100% of the premiums for excess coverage with after-tax pay may nonetheless have additional taxable income due to the excess coverage as deemed by the IRS measurement of value.

## DETERMINING THE AMOUNT OF INCOME TO IMPUTE

If an employer pays the premiums for all of an employee’s group term life insurance coverage, determining the amount to impute is easy: subtract \$50,000 from the total group term life insurance coverage in effect for the employee during the year and multiply the remaining coverage amount by the applicable Table I rate. If the employer does not pay all of the premiums, but the employee’s contributions are made on a pre-tax basis, this same calculation applies.

If the employee pays all or part of the premium for any group term life insurance coverage (including the first \$50,000) on an after-tax basis, an additional calculation is needed. After finding the Table I cost of all coverage above \$50,000, as described above, deduct from that amount all of the employee's after-tax contributions toward the coverage (including contributions for coverage under \$50,000). If the result is a positive number, that is the amount to impute.

**NOTE:** If an employee is covered by more than one group term life plan, the IRS requires aggregation of all coverage so that the employee may not exclude the cost of more than \$50,000 in coverage for the year.

## W-2 REPORTING AND FICA TAXES

As taxable income, the imputed amount must be included in the employee's taxable income reported on Form W-2, but the employer is not required to withhold for the employee's federal income tax liability. FICA taxes apply, however, and the employer must withhold the employee's portion of FICA taxes. The employer also must pay its portion of FICA taxes and remit both the employer and employee FICA amounts. For 2010, the Social Security tax rate is 6.20% on annual pay up to \$106,800. The Medicare tax rate is 1.45% on all pay, without a maximum limit. (See the following link: <http://www.ssa.gov/pressoffice/colafacts.htm>.)

## OTHER REASONS TO IMPUTE INCOME ON GROUP TERM LIFE INSURANCE

In addition to imputing income based on an employee's coverage over \$50,000, an employer might be required to impute income for employees in a few other circumstances.

### DISCRIMINATION IN FAVOR OF KEY EMPLOYEES

If group term life insurance discriminates in favor of key employees (usually by limiting eligibility to certain owners and officers or by offering those individuals broader coverage), additional imputing requirements apply. The employer is required to impute income to these individuals on their entire coverage amount – not just amounts exceeding \$50,000. In addition, the cost of coverage to be imputed is the greater of the Table I cost or the actual cost of coverage. (Any after-tax contributions would be deducted from the cost.) Actual cost for this purpose may not be the premium rate paid to the insurer; it may be a higher amount determined according to IRS regulations.

### DEPENDENT LIFE INSURANCE

The cost of employer-provided term life insurance on the lives of an employee's dependents must be imputed to the employee unless the benefit provided is \$2,000 or less. If the \$2,000 limit is exceeded, all dependent life insurance, including the first \$2,000, is taxable. The Table I rates – using the dependents' ages to select the applicable rate – must be used in calculating the amount to impute to the employee. As with the employee's life insurance, any after-tax contributions toward the cost of coverage are deducted when determining the amount to impute. If the dependent coverage is no greater than \$2,000, the value of the coverage is excluded from the employee's income as a *de minimis* fringe benefit.

# WEBCASTS

## COMPENSATION BASICS FOR THE HR GENERALIST

**November 16, 2010**  
**2:00 PM EASTERN TIME**

**Presented by Debbi Davidson**  
**CCP, HR Partner Senior Consultant**

During this webcast, we will share key components of typical compensation programs for the benefit of HR generalists, who may not be familiar with the sometimes highly technical language of compensation. In addition to discussing concepts such as compensation philosophy, job analysis and evaluation, market analysis, salary ranges, incentive pay, and pay for performance, we will describe how compensation fits into the total rewards framework and share compensation trends and issues facing organizations today.

### **PARTICIPANT ACCESS**

Advance reservations are required to participate. [Click here](#) to RSVP for this call.

## SMALL EMPLOYER SOLUTIONS - VOLUNTARY BENEFITS

**December 21, 2010**  
**2:00 PM EASTERN TIME**

**Presented by Jay Hutchins**  
**Colonial Life, Vice President, Broker Marketing & Sales**

Voluntary benefits play a key role in the workplace of the future. According to a recent white paper released by Colonial Life & Accident Insurance Company, American workers who are looking at their benefit needs five years into the future say many voluntary benefits will be important to them – but their employers may not be hearing the message.

Join us for an educational webcast focused on the small employer. We will explore:

- The importance of voluntary benefits
- Workplace dynamics
- How employers can combat employee demands
- Big picture approach to benefits
- Appropriate voluntary product offerings
- One-to-one benefits counseling
- Flexible technology
- Choosing a voluntary benefits partner

### **PARTICIPANT ACCESS**

Advance RSVP is required to participate in this call. [Click here](#) to RSVP for this call.

# KEY CONTACTS

## U.S. HUMAN CAPITAL PRACTICE OFFICE LOCATIONS

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