HUMAN CAPITAL PRACTICE

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HRFocus

February 2010 — Issue 32

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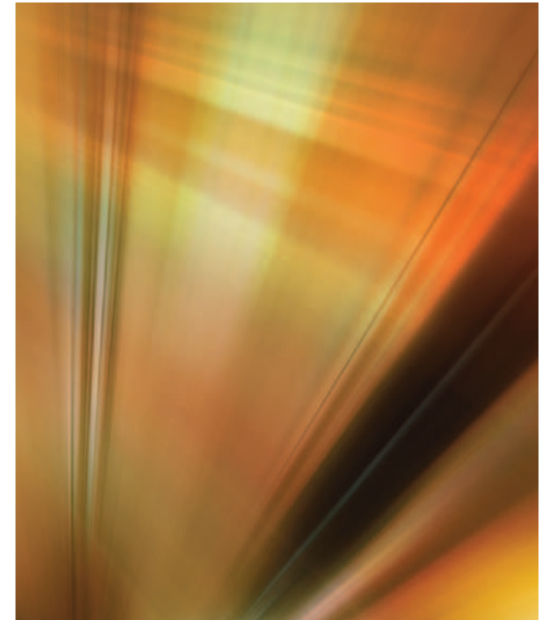

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LEGAL & COMPLIANCE

COBRA SUBSIDY EXTENSION: DOL ISSUES MODEL NOTICES FOR IMPLEMENTATION

On January 13, 2010, the Department of Labor (DOL) posted on its website model notices in connection with the COBRA subsidy extension. Employers have been eagerly awaiting these items for two reasons. One, so that they could provide information about the subsidy extension to required recipients and two, in order to satisfy the statutory notice requirements and avoid promising more than the statute requires.

As background, an extension of the COBRA subsidy was enacted on December 19, 2009 and made the following major changes to the existing requirements:

- Extended subsidy eligibility to February 28, 2010 (previously December 31, 2009)
- Extended the maximum period for an individual to receive the subsidy by six months, so an individual who meets the requirements may receive the subsidy for up to 15 months (previously nine months)
- Fixed a glitch that made the subsidy unavailable to someone who otherwise qualified for it if that individual's COBRA coverage did not begin by the last eligibility date (now February 28, 2010, previously December 31, 2009)

Transition provisions in the extension legislation permit retroactive payment of certain COBRA premiums by assistance-eligible individuals (AEIs) whose maximum nine-month subsidy period has expired. The legislation also requires notification regarding the extension and transition provisions, and the DOL's model notices are intended to fulfill those notification requirements. For most current COBRA subsidy recipients, notice is required to be provided no later than February 17, 2010. For those who are entitled to make

retroactive premium payments, however, notices regarding the transition provisions may be required earlier. In the case of a plan that administers COBRA on a calendar-month basis, for example, some notices will be required as of February 1, 2010.

Questions about the extension – particularly its notification requirements – are pouring in from employers. In response, Willis' National Legal and Research Group hosted a teleconference regarding the extension on January 5, 2010. Please contact your Willis representative for the access link to the recorded replay of that teleconference and for a copy of the slides used during the program.

As if these new developments were not already enough for employers to handle, COBRA subsidy-extending legislation containing different, additional changes is now advancing through Congress. If enacted, employers will have new COBRA compliance duties. Willis NLRG will closely monitor developments and share them in *HR FOCUS* as they become known in the months ahead.

HEALTH CARE REFORM PROPOSALS INCLUDE EXPANDED IRS ROLE

This article was prepared prior to Republican candidate Scott Brown's election as Massachusetts Senator. His election appears to have stalled forward momentum on healthcare reform. Although the IRS role described in the following article continues to represent a valid analysis if healthcare reform proceeds, please note that much will depend on what the Democrats ultimately salvage from their healthcare reform proposals.

The health care debate has sparked huge controversy this year. No matter how things unfold in Washington, it appears the IRS's enforcement role may be expanding in powerful new ways. A recent *USA Today* article examined the implications of health care reform legislation for IRS enforcement. According to the article, the IRS is poised to become the nation's health coverage enforcer. (**"Health bills could expand IRS role," January 3, 2010**)

Many of the IRS's newly expanded duties relate to the anticipated mandate for health insurance. If Congress enacts a health care reform measure this year, taxpayers would likely have to prove on their federal tax returns that they maintain coverage. Those who fail to do so would pay a penalty to the IRS. (A controversial element of the leading Congressional proposal concerns the appropriate penalty level. Some observers fear that if the penalty is too low, healthier individuals may prefer to pay the penalty and simply obtain coverage when they need it – since the reform proposals include rules that eliminate preexisting condition exclusions and other restrictions that might otherwise prevent purchasers from buying coverage except when needed.)

The IRS also would distribute as much as $140 billion a year in new government subsidies to help small employers and as many as 19 million lower-income people buy coverage. In addition, the IRS would collect hundreds of billions of dollars in new fees on employers, drug companies and device makers, according to the non-partisan Congressional Budget Office (CBO). The CBO estimated that the IRS would need $5 billion to $10 billion in the first decade to cover the costs of its expanded role. The IRS's annual budget is currently $11.5 billion. The sharp jump in anticipated budget requirement for the Internal Revenue Service offers perhaps the best indication about the future growth of the agency's size and power.

As Congress continues to wrestle with how to proceed with healthcare reform efforts, keeping your Senators advised of your legislative concerns remains of utmost importance.

MASSACHUSETTS INDIVIDUAL MANDATE UPDATES

Massachusetts requires that, with limited exceptions, every Massachusetts resident age 18 or older obtain health insurance. This is known as the individual mandate. A tax penalty is assessed against residents who do not comply. Since 2009, not only must the resident maintain health coverage, but the coverage must meet certain requirements. The Minimum Creditable Coverage (MCC) regulations require that individuals hold coverage that provides benefits for certain types of services.

COVERAGE REQUIREMENTS

The MCC regulations also mandate annual deductibles, out-of-pocket expenses and annual maximums. Key coverage requirements necessary to satisfy MCC standards include:

- A comprehensive set of services (e.g., doctors' visits, hospital admissions, diagnostic, surgery, mental health and prescription drug coverage)
- Preventive care services
- Annual deductibles for in-network services no greater than $2,000 for an individual and $4,000 for a family
- Annual out-of-pocket maximums for in-network services (for plans with up-front deductibles or co-insurance for in-network services) no greater than $5,000 for an individual and $10,000 for a family
- No caps on total benefits for a particular illness or for a single year
- Annual deductibles for prescription drugs no greater than $250 for an individual and $500 for a family

Effective January 1, 2010, the list of required services expands to include such additional items as maternity and newborn care, and radiation therapy and chemotherapy.

Special MCC rules govern High Deductible Health Plans (HDHP) coverage. Previously, so long as the HDHP corresponded with federal Health Savings Account (HSA) rules, the HDHP automatically met MCC requirements. For 2010, the HDHP must not only comply with the federal requirements (to be HSA-compatible), but also with certain aspects of the MCC requirements (to the extent that the requirements are not inconsistent with the HSA rules). The carrier (or employer) must also "facilitate access" to an HSA to enable individuals covered by the HDHP to establish and fund an HSA. The MCC regulations were recently amended to provide that the HDHP could also be paired with a Health Reimbursement Arrangement (HRA) as an alternative to the HSA. This change is effective January 1, 2010.

OTHER CHANGES

Other MCC amendments take effect on January 1, 2011. One important change will preclude plans from imposing dollar caps on prescription drug benefits. In addition, if a health plan provides dependent benefits it must provide the same core services and "broad range of medical benefits" to those dependents that are provided to other covered individuals. (According to the Health Connector, this change is intended to ensure that the plan extends maternity benefits to pregnant dependents.

A health plan that does not meet every element on the MCC list can request the Health Connector to determine if it is nonetheless compliant because it is actuarially equivalent to certain plans offered by the Health Connector. A copy of the application can be found on the **Health Connector's website**.

APPLICABLE PENALTIES

The 2010 penalties for non-compliance with the individual mandate have also been released. Penalties accrue for each month that a taxpayer fails to comply. A lapse in coverage of no more than 63 days is permitted. (This 63-day rule corresponds with federal HIPAA portability standards for maintaining valid "creditable coverage.") Please note that for 2009, a recently released **Administrative Bulletin** clarifies that for penalty calculation purposes, taxpayers avoid the penalty if they had lapses in coverage consisting of three or fewer consecutive months.

The maximum penalty for tax year 2010 will be $93 a month ($1,116 for an entire year of non-compliance) for a person 27 or older with income over 300% of the federal poverty level, which in 2009 is $32,496 or greater for singles). For 2009, the penalty was $89 a month or $1,068 annually. For individuals up to age 26 with income over 300% of the federal poverty level, the penalty will be $66 a month ($792 annually). Penalties are waived for individuals with incomes up to 150% of the federal poverty level ($16,248). For individuals with incomes between 150.1% and 300% of the federal poverty level, penalties increase with increasing incomes. Penalties for married couples who can afford health insurance but who lack coverage will equal the sum of the penalties for each spouse. Information about the 2010 tax penalties can be found **here**.

Massachusetts taxpayers need information from MA 1099 HC in order to complete their state tax returns. A copy of the 2009 MA 1099 HC can be found on the **Massachusetts Department of Revenue website**. Employers, regardless of size, generally must provide the MA 1099 HC form to employees who reside in Massachusetts and are covered under the employer's health plan by January 31 each year. For insured plans written in Massachusetts, the carriers will prepare and provide the form. For insured plans written outside of Massachusetts, as well as self-insured plans, the responsibility falls on the employer. Employers should confirm with their insurers or third-party administrator whether it will be completing the 1099 HC on the employer's behalf. (Applying state law on self-funded plans raises interesting ERISA preemption legal questions which reach beyond the scope of this article. Suffice it to say that most employers are simply choosing to comply.)

This year, the MA 1099 HC form reflects the requirement that coverage must meet all MCC mandates. Although Massachusetts law cannot require employers to provide coverage that meets these requirements, organizations that complete the form will need to know whether sponsored coverage for Massachusetts employees is considered creditable or not. Information about the 2009 (and 2010) MCC requirements can be found at the **Health Connector's website** (the Health Connector is the entity responsible for several aspects of the Massachusetts Health Care Reform Act). The **MCC Checklist** is particularly helpful in determining whether coverage is creditable or not.

DOL ISSUES REGULATORY AGENDA

Late last year the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) released its newest Semi-Annual Regulatory Agenda.

Most notably, for health plan sponsors:

- Interim final regulations on the Mental Health Parity and Addiction Equity Act are expected to be issued by April 2010.
- In September 2010, DOL plans to issue final regulations regarding the portability of health coverage, while addressing amendments made to HIPAA by the Children's Health Insurance Program Reauthorization Act of 2009.

In addition, for employer retirement plan sponsors:

- DOL intends to amend the regulatory definition of a "fiduciary" for plan investment advisers to include pension consultants and other plan advisers who do not meet the current regulatory definition. DOL plans to issue proposed regulations on this issue in June 2010.

- Proposed investment advice regulations are expected to be issued in February 2010. As we have reported, the agency recently withdrew its final regulations interpreting the investment advice provisions of the Pension Protection Act of 2006 (PPA) and the accompanying administrative class exemption. It appears the re-proposed rule will not include an administrative class exemption.

- Service provider defined contribution plan fee disclosure regulations are expected to be issued in final form in May 2010, while the participant fee disclosure regulations are expected to be issued in final form in September 2010. Various legislative proposals on plan fee disclosure are still pending in Congress.
- Proposed plan asset regulations (regarding a safe harbor for depositing participant contributions) are expected to be finalized in January 2010.
- Proposed regulations regarding benefits statements are expected to be issued in September 2010.
- In April 2010, DOL intends to issue final regulations regarding Qualified Domestic Relations Orders (QDROs) that are issued late, or are issued after another QDRO or that revise another QDRO. These regulations would implement Section 1001 of PPA.

The DOL also announced that the agency will make it a top priority to encourage the annuitization of defined contribution plan benefits. DOL Secretary Solis said in a video webcast that her department is working with the U.S. Treasury Department "to determine how best to enhance retirement security by facilitating access to a lifetime stream of income at retirement."

DOMESTIC PARTNER BENEFITS AND TAXES

Group health plans increasingly offer domestic partner benefits, but these benefits often come with unexpected costs because of the tax treatment accorded domestic partners. Plan participants frequently assume that the benefits taxation rules for domestic partners are the same as those for legal spouses. However, benefits that are not taxable when provided to a spouse are taxable if those identical benefits are provided to a domestic partner. For federal tax purposes, domestic partners are not included in the definition of a spouse, and so federal tax benefits do not apply to domestic partners (except in rare instances where the domestic partner might qualify as the employee's dependent).

Plan sponsors that offer benefits to domestic partners must calculate the value of the benefits. That amount is considered taxable pay and must be shown on the employee's W-2 statement.

Determining how to measure and assess health coverage value is often difficult. Many employers assess an amount based on COBRA value (minus the 2% administrative fee) as the COBRA cost is supposed to represent the full unsubsidized cost of coverage. The IRS appears content with employers who take "reasonable" steps to clearly identify family members who are entitled to receive tax-favored coverage and distinguish them from domestic partners who are not legally entitled to such treatment. Hopefully, the IRS will offer detailed guidance in the future, but there are no clear signs for now.

CMS CREDITABLE PRESCRIPTION DRUG COVERAGE: FILING REMINDER

The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires all plan sponsors – even those who did not provide retiree prescription drug benefits – to distribute notices to Part D-eligible individuals explaining the creditable coverage status of their prescription drug benefits. This notice tells recipients whether or not the plan's prescription drug coverage is considered "creditable" as measured against Medicare's Part D standard prescription drug benefit. Creditable status is important since a Part D-eligible individual will be assessed a Part D late enrollment fee if he or she initially waives enrollment in Medicare's prescription drug benefit and later enrolls after a break in creditable coverage of 63 days or longer. Details of this notice obligation are available in the on-line *Willis Compliance Manual*. (Please check with your Willis representative to obtain access to the manual.)

ADDITIONAL REPORTING DUTY TO CMS

A second and perhaps more easily overlooked disclosure requirement is that group health plan sponsors providing prescription drug coverage to Medicare Part D-eligible individuals *must also report creditable status directly to CMS*. Specifically, the group health plan must communicate whether its prescription drug coverage qualifies as creditable or non-creditable. The government needs this information to effectively coordinate Medicare Part D enrollment.

All plan sponsors providing prescription drug coverage are required to make this disclosure – even if they do not make coverage available to retirees. Reporting to CMS about the plan's creditable status is due within 60 days after the first day of the new plan year. Calendar-year plans must submit the disclosure to CMS by March 1, 2010. Additional information about the CMS reporting duty is also contained in the *Willis Compliance Manual*.

SINCE YOU ASKED:

ADA AND REASONABLE ACCOMMODATION

If an otherwise qualified individual with a disability poses a direct threat to employees or others, can the employer take action? Yes. In fact, failure to do so may result in liability for the employer under the Occupational Safety and Health Act, or even applicable state law. Though the Americans with Disabilities Act raises important concerns and considerations, nothing in the ADA prevents an employer from protecting its workforce. Therefore, an employer can require that all employees, including those who fall within the definition of a qualified individual with a disability under the ADA, do not pose a direct threat to the health or safety of others.

Under the ADA, the term direct threat is narrowly defined as a situation that poses "a significant risk to the health or safety of others which cannot be eliminated by reasonable accommodation." Typically, direct threats arise in connection with contagious diseases and infections. The more interesting issue is whether someone who poses a direct threat only to himself or herself, but not to others, fits into the "direct threat" defense. For example, in *Chevron USA Inc. v. Echazabal* [536 U.S. 73 (2002)], the employee reportedly suffered from chronic hepatitis C and posed a direct threat to himself, but apparently not others. Although the employee was successful in the lower court, the U.S. Supreme Court held that in accordance with EEOC regulations, "direct threat" includes a situation where someone poses a substantial risk of harm to themselves.

When an employer becomes aware of a situation that may pose a direct threat, it should not make the final determination. An employer may want to discharge an employee immediately out of fear that the employee's medical condition poses a direct threat to the workplace. An employer seeking professional advice often finds that this belief is based on fear, not on any medically supportable evidence. If an employer is not cautious and acts solely upon its own uninformed lay opinions, it may violate the ADA.

HR CORNER

DO MERIT INCREASES PROMOTE HIGH PERFORMANCE?

Halogen Software, a provider of employee performance and talent management solutions, recently gathered a panel of 10 experts in human resources to debate an equal number of key issues in human capital management. As you may imagine, given their different backgrounds and philosophies, the experts disagreed with one another a great deal. We chose one question and summarized some of their responses to give you a flavor of the panel's views – and the level of disagreement about the ever-inexact art of motivating and managing people. Here are their thoughts and insights as to whether merit increases motivate employees.

Josh Bersin, head of Bersin & Associates, which offers research and advisory services on corporate learning: "Yes. My experience in my own career and with many organizations is that merit pay and individual pay-for-performance programs are very important elements in a high-performing organization. [But] they must be accompanied by strong goal setting, transparency (showing the entire organization who the high-performing groups are), and a focus on how to succeed."

Peter Cappelli, professor of management at The Wharton School and director of its Center for Human Resources: "Probably not. The reason is that at present, the differences in merit pay are pretty trivial. No one wants to give pay cuts, and with low inflation and increase pools of about 2%, even a great performer is likely to get around 4%. So they are unlikely to want to kill themselves for that. It was high-inflation environments where merit pay increases mattered."

David Creelman, head of Creelman Research and writer and worldwide speaker on critical issues of human capital management: "I'm not convinced they do. There are lots of high-performing people in nonprofits who don't get merit increases. It's really a matter of culture. If you have a money-focused culture, then a lack of merit increases may signal to the person that there is no point trying. [In other cultures,] community, purpose, and pride are motivators."

Kris Dunn, vice president of people at software firm Daxko, and HR blogger: "There are lots of ways to get [the desired] discretionary effort (career pathing, promotions, incentive pay, etc.), but common merit pay alone will not lead to the promotion of sustained high performance."

Sharlyn Lauby, head of consulting firm Internal Talent Management Group and also an HR blogger: "No. Everyone has a price for which they will only tolerate so much. There are countless studies that show money is not the ultimate motivator. Even in tough economic times."

Ed Lawler, author and professor of business at the Marshall School of Business: "The research on merit increases shows that they are a waste of time and money with respect to influencing performance."

Laurie Ruettimann, SPHR and HR blogger: "No one wants to work for an employer who pays poorly and doesn't share the success of the company with its workforce."

This article provided by BLR.

MEASURE TODAY WHAT YOU HOPE TO CHANGE TOMORROW

When it comes to worksite wellness, the evaluation plan is as important as the wellness plan itself. While most employers implement worksite wellness programs hoping to curb their future health care costs, many unfortunately have neither a strategy nor the resources to measure the full impact of these efforts. This measurement challenge is complicated by lack of data, and restrictions in budget and/or time to invest in the gathering and analysis of data. A true return on investment (ROI) analysis can be a daunting task that typically involves an integrated data warehouse to collect information from various resources, a savvy analyst and access to long-term information from program participants. A sophisticated return on investment analysis is not, therefore, realistic for most organizations. A basic evaluation, however, can be accomplished within most organizations with worksite wellness programs.

Evaluating your worksite wellness efforts from day one is essential to sustain and justify future funding for your program. Understanding what is and what is not positively impacting your worksite population will help you improve your program year after year. Having a solid evaluation plan is an essential part of your overall business plan, and even if you already have a wellness program in place, creating an evaluation plan is still not only possible, but worthwhile. Answering the questions below will help you get started or review your current efforts:

- What are your key wellness program goals?
- What data sources are necessary to measure progress for each goal?
- How will you collect participant feedback about your program?
- What types of programs need to be part of your future plans to begin a more comprehensive evaluation effort?
- What key organizational indicators are already being used by departments in your company, such as Safety, Human Resources, Finance, Benefits and Risk Management?

According to our soon-to-be released 2009 Willis Health and Productivity survey, only about one-third of the respondents indicated that for their management, achieving a positive ROI was not a program goal. Most others believe their management expects to see a positive ROI in two to three years. When asked which measurements are actually used to evaluate their program's effectiveness, respondents reported most often using participation, claim costs over time and usage of wellness program services. Do you have the information you need to answer questions from your management about the impact of your worksite wellness program?

One of the most basic ways to evaluate your wellness program over time is to track participation rates in its various facets from the start. It is also important to try and capture program satisfaction information from participants.

This can be done in employee-feedback surveys taken at the end of each program module or annually. Another important metric is the risk stratification of your worksite population. Health Risk Assessments (HRA) or health plan utilization data can often be broken out into helpful risk categories such as "high," "moderate" and "low" risk groups. These groups can be tracked over time to determine if more people are migrating into moderate and lower risk groups and fewer are moving into higher risk groups. Your HRA vendor may also be able to give you an overall health risk score for the participant group. This score can be tracked over time as well. Other types of goals, such as reducing the number and type of emergency room visits or increasing well doctor visits for adults, can be tracked through medical claim data. These key metrics should correlate with your goals from your wellness program business plan. Your goals should also be clearly identified in terms of what you hope to achieve; for example, increase compliance to recommended routine preventive care checkups by 5%, or from "x" to "y." Identifying quantifiable goals helps you evaluate success.

In 2010, make evaluation one of your major wellness program goals. Begin collecting and analyzing currently accessible data. Then, establish the baseline data points and outline specific goals for each data point you plan to track over time.

Other potential cost savings for worksite wellness plans involve disability, workers' compensation, productivity and absenteeism. This type of data may not be as readily accessible or even being captured within your organization. It is important, however, to recognize the value of capturing this information to help analyze the full impact of your worksite wellness efforts. A gradual, evolving evaluation plan should be your goal. Once you have collected and measured such areas as program participation rates and satisfaction, your evaluation efforts should begin to include additional areas such as true behavior change, health care spending and productivity.

Share the overall results of any type of needs assessment, HRA or evaluation effort with your key stakeholders, wellness committee members and your employees. In 2010, make evaluation one of your major wellness program goals. Begin collecting and analyzing currently accessible data. Then, establish the baseline data points and outline specific goals for each data point you plan to track over time. Any gaps in information and resources may afford you the opportunity to collaborate with others in your organization or set future evaluation objectives necessary to achieve your overall evaluation plan. You cannot manage and change tomorrow what you are not measuring today.

WEBCASTS

HR STAFFING AND SERVICES 2009 SURVEY

FEBRUARY 16, 2010
2:00PM EASTERN TIME

Presented by
Jennifer Barton, SPHR, MBA, HR Partner National Practice Leader and Debbi Davidson, CCP, HR Partner Senior Consultant

This webcast will cover the results of the 2009 HR Staffing and Services Survey conducted by our HR Partner team last fall. In this compelling hour we will uncover key themes from the survey surrounding HR department staffing, organizational activities and service delivery. Join us as we share vital information regarding:

- Specialist vs. generalist staffing levels
- Benchmarking data, such as HR staffing per FTE, turnover rates, HR labor expenses as a percent of revenue, and other metrics
- Allocation of HR department time on various functions and activities
- HR outsourcing trends
- Reporting relationships
- And much more...

HR practitioners won't want to miss this important opportunity as they plan for 2010. We look forward to your participation!

Participant Access
Advance reservations are required to participate. **Click here** to RSVP.

2009 WELLNESS SURVEY FINDINGS

MARCH 16, 2010
2:00PM EASTERN TIME

Presented by
Cheryl Mealey, CHES, Wellness Consulting National Practice Leader and Leah Fidler, MHPE, CHES Wellness Consultant

The 2009 Health and Productivity Survey was completed by more than 1,600 respondents representing a wide array of company size and industry segments. Join us for this informative webcast that will assist you in benchmarking your wellness initiatives against those of other organizations. Topics covered include:

- Building a culture of health
- Senior leadership support
- Use of incentives
- Measuring return-on-investment
- Program components
- and more...discover "lessons learned" and best practices that you can apply to your own program

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