GROOM LAW GROUP, CHARTERED

2007 Employee Benefits Seminar

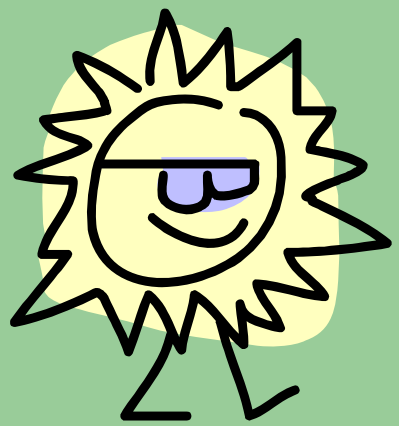
Current Health and Welfare Plan Issues

Presenters: **Tom Fitzgerald (Moderator)**
Matthew Calloway
Chris Keller
Christy Tinnes

Topics: **Cafeteria Plans**
ERISA Fiduciary Issues
State Initiatives
Wellness Program Trends

Materials: **Presentation**

Hot Health & Welfare Plan Issues



Tom Fitzgerald, Chris Keller,

Christy Tinnes, & Matt Calloway

October 24, 2007

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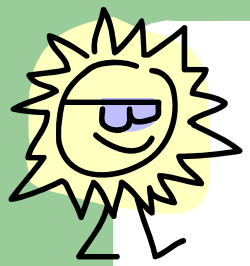
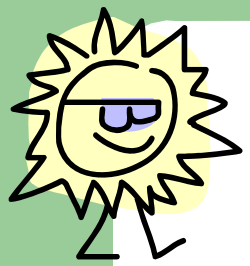


Hot Health & Welfare Plan Issues

- Welfare Plan Fiduciary Issues to Watch
- Transparency
- Wellness Programs: New Regulations & Top 5 Questions
- New Cafeteria Plan Regulations
- Update on State Initiatives
- The Very Latest on Massachusetts



Welfare Plan Fiduciary Issues to Watch

- Impact of Current DOL Regulatory Initiatives on Welfare Plans
  - Service Provider Exemption
  - Propose Form 5500 Revisions
- Recent case addressing terms incorporated into a “wrap document.”
- Recent cases considering whether separate classes of coverage were part of a single plan.

Current DOL Regulatory Initiatives

- Forthcoming proposed regulation amending DOL's regulation under ERISA section 408(b)(2).
  - ERISA requires fiduciaries to act solely in the interest of plan participants and beneficiaries and for the exclusive purpose of providing benefits and deferring reasonable expenses of administering the plan.
  - To accurately assess whether amounts paid to a service provider (such as a third party administrator) are reasonable, a fiduciary must know what the plan is paying for services.

Current DOL Regulatory Initiatives

- (408(b)(2) Continued . . .)
  - Fiduciaries must also know whether the service provider receives any consideration from a third party in connection with services provided to the plan.
  - DOL's forthcoming proposed regulation will require service providers to disclose material conflicts of interest, including fees received from third parties in connection with provision of services.
  - Proposed rule expected to be issued by the end of 2007.

Current DOL Regulatory Initiatives

- Proposed Form 5500 Schedule A Revisions
  - Proposed rule adds a check box to the Schedule A to permit plans to identify situations in which the insurance company or other organization that provides some or all of the benefits under a plan has failed to provide Schedule A information.
  - Space would also be provided for the administrator to indicate the type of information that was not provided.
  - Final rule expected to be issued this fall.

Health and Welfare Plan Drafting

- May plan fiduciaries rely on terms contained only in the documents incorporated by reference into the wrap document?
- Admin. Comm. of Wal-Mart Stores, Inc. Health and Welfare Plan v. Gamboa, 479 F.3d 538 (8th Cir. 2007).
  - Self-funded plan.
  - Subrogation provision contained in a summary plan description benefits book incorporated by reference into the wrap document.
  - No subrogation provision in the wrap document.

Health and Welfare Plan Drafting

- (Gamboa, Continued . . .)
  - ✓ Court holds that the summary plan description benefits book incorporated by reference into the wrap document is a plan document.
  - ✓ Plan fiduciaries can rely on the subrogation provision contained in the benefits book.

Health and Welfare Plan Drafting

- One Plan or Multiple Plans?
- House v. Am. United Life Ins. Co., No. 06-30168 (Sept. 4, 2007).
  - Law firm obtained group life and disability coverage with one class of life insurance coverage and three classes of disability coverage.
  - Firm partners were covered by a separate class of disability coverage and paid 100% of their own premiums.

Health and Welfare Plan Drafting

- (House Continued . . .)
  - When a Partner's disability claim was denied, Partner sued the insurer for benefits and penalties under state law.
  - Issue was whether the class of disability benefits offered to Partners was a separate "plan" that was not governed by ERISA because it did not cover employees.

Health and Welfare Plan Drafting

- (House Continued . . .)
  - ✓ Court held that the class of disability benefits offered to Partners was not separate from the life and disability plan as a whole, which also benefited employees.
  - ✓ Even though Partners paid 100% of their premiums, they received the benefit of a single rate structure along with the other classes of disability benefits.
  - ✓ Neither the multi-class disability coverage as a whole nor the specific class of Partner coverage met the DOL's safe harbor (29 C.F.R. 2510.3-1(j)).

Health and Welfare Plan Drafting

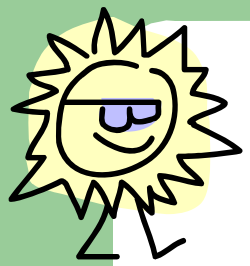
- One Plan or Multiple Plans?
- Loren v. Blue Cross & Blue Shield of Mich., No. 06-2090 (6th Cir. 2007)
  - Self-insured plan including two health care options.
  - BCBSM was the TPA for a self-insured PPO health care plan option.
  - Another health care plan option was an HMO designed and administered by a different company.

Health and Welfare Plan Drafting

- (Loren Continued . . .)
  - Plaintiffs bringing claim against BCBSM were enrolled in the health care option not administered by BCBSM.
  - BCBSM argued that plaintiffs could not bring the claim because they were not participants in or beneficiaries of an ERISA plan connected to BCBSM.
  - Plaintiffs argued that all of the coverage options were a single ERISA plan.

Health and Welfare Plan Drafting

- (Loren Continued . . .)
  - ✓ Court looks to a proposed regulation governing the group health plan portability provisions of HIPAA (69 Fed. Reg. 78,888 (Dec. 30, 2004)).
  - ✓ "Strong presumption" that filing of only one ERISA plan document indicates employer intent to create only one plan.
  - ✓ Court finds that there was one plan because there was only one ERISA identification number and there was a single plan document which did not include evidence of intent to create separate plans.



What is Healthcare Transparency…

- The availability of information to support knowledge and comparison of the cost and quality of health care.
- Consumer-driven health plans (CDHPs), e.g., HSAs, HRAs, rely upon ability of consumers to know and compare quality and costs of care.

…and Why Does It Matter?

- Proponents say that transparency is essential to bringing health care costs under control:
  - Promotes accountability
  - Enables purchasers to measure/reward performance
  - Increases competition

Executive Order 13410 (8/22/06)

- Promote quality and efficient health care in health care programs sponsored or administered by the Federal government through the use of:
  - Health information technology
  - Transparency regarding health care quality and price
  - Better incentives for Program Beneficiaries, Enrollees, and Providers
- Make relevant information available to beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in private sector and non-federal Public sector.

4 Cornerstones of Value-Driven Health Care (DHHS 11/17/06)

- **Interoperability of Health Information Technology ("HIT").** Establish standards to enable health information systems to communicate and exchange data securely.
- **Price Transparency.** Develop standards that afford consumers a clearer idea of overall costs of treatment for an episode of care.
- **Quality Transparency.** Develop accepted definitions and standards to measure quality; gather and facilitate sharing of aggregated health information through electronic records.
- **Incentives for Value-Driven Health Care.** Design contractual arrangements that reward the sale & purchase of high-quality, competitively-priced health care (e.g., HSAs, HRAs, HPNs).

Transparency Obstacle #1 - Physician Lawsuits

WA State Medical Ass'n v. Regence BlueShield. (9/21/06)

-Regence dropped 500 physicians from Select Network in connection with introduction of HPN.

-Suit alleged that Regence used flawed methodology and inaccurate information to exclude physicians from plan resulting in:

- Violation of Unfair Business Practices Act
- Defamation/Libel
- Intentional Interference with Commerce
- Breach of Contract

-Regence discontinued network, but physicians still sought damages.

Transparency Obstacle #1 - Physician Lawsuits

WA State Medical Ass'n v. Regence BlueShield (continued)

August 2007- Suit settled. Terms of settlement require Regence to:

- Explain to doctors methodology before implementing any new or revised performance program.
- Seek input from the WSMA in areas including timeliness of data, comparability of physician practices and methods for communicating grades to doctors.
- Notify doctors at least 10 days before releasing new performance scores.
- Post physician scores and reports on its Web site with explanations of the results.
- Give doctors a chance to appeal their scores in a timely manner before they go public, first through an internal review process.

Transparency Obstacle #1 - Physician Lawsuits

- Potential liability associated with establishing networks based on provider quality/efficiency. Possible provider claims include:
  - Tortious Interference with Contractual Relations
  - Defamation
  - Antitrust
  - Contract Theories
  - Doctrine of Fair Procedure

Transparency Obstacle #2 - The Well-Drafted Contract

- Confidentiality of Rates
  - Existing contracts that include provisions requiring that rates be kept confidential may need to be amended.
- Other Limitations
  - Provisions limiting plan's ability to take actions that would steer patients away from a provider
  - Limits on plan's ability to terminate providers

Transparency Obstacle #3 - Any Willing Provider Laws

- State “any willing provider” laws may limit a plan’s ability to restrict and/or tier its provider network
  - Network limitations generally must be reasonable, uniformly applied, and nondiscriminatory
  - Generally permit uniformly applied quality standards for admission to network

Issues for Fiduciaries

- DHHS asks employers to sign statement of support for health care transparency, however –
- A fiduciary must keep in mind the hat he is wearing …

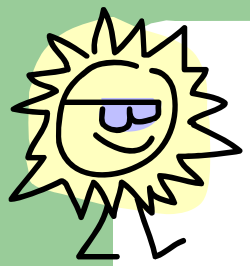
I love transparency because it promotes efficient/higher quality care for plan participants

v.

I love transparency because it saves the company money, thereby securing my bonus this year

Issues for Fiduciaries

- Transparency will increase information available to fiduciaries.
  - Must identify obligations with respect to increased information
  - Need to maintain division between oversight of quality and practice of medicine



Wellness Programs: New Regulations & Trends

- Final Regulations issued December 13, 2006.
- Apply to plan years beginning on or after July 1, 2007 (January 1, 2008 for calendar year plans).
- DOL says will begin more actively enforcing after this date (especially with respect to wellness).
- We have seen increased monitoring/inquiries from DOL, HHS, and IRS related to wellness programs.

HIPAA Wellness Rules
Five Factors

#1 - Reward for all health standard-based wellness programs cannot exceed 20% of cost of single employee coverage.

#2 - Must be reasonably designed to promote good health.

#3 - Must give plan participant opportunity to qualify at least once per year.

#4 - Must allow “reasonable alternative” to those who can show it is unreasonably difficult due to medical condition, or medically inadvisable, to satisfy standard. May require doctor’s certification.

#5 - Must disclose availability of reasonable alternative standard in plan material describing wellness program.

Top 5 Wellness Questions:
Does HIPAA apply to all wellness programs?

- Only applies if program requires individual to meet health standard to obtain reward. If "participation-only" standard, outside of HIPAA rules (including 20% limit).

Subject to HIPAA Wellness

- Plan has lower copay for employees with low cholesterol.
- Plan charges surcharge on employees who smoke.
- Plan rewards premium holiday if employee meets weight loss goal.

Outside of HIPAA Wellness

- Plan reimburses cost of fitness center.
- Plan waives copayment for cost of well-baby visit.
- Plan reimburses smoking cessation class, regardless of whether employee stops smoking.
- Plan rewards employee for attending monthly health seminar.

Top 5 Wellness Questions:
How does the 20% Limit Work?

- Rewards for health-based wellness programs may not exceed 20% of cost of employee coverage.
- Add all health-based rewards together (but only have to count rewards that are health-based). Participation-only rewards are not subject to the 20% limit.
- Cost of coverage includes employer + employee contributions. For example, if employer contribution is $60, employee contribution is $40, total cost is $100. Reward limit is $20.
- If wellness program only available to employees, only count 20% of single coverage (even if employee has family coverage).
- If wellness program available to dependents, can count 20% of family coverage (but not 20% per person).

Top 5 Wellness Questions:
Do we have to give everyone a reasonable alternative?

- Must allow "reasonable alternative" to those who can show it is unreasonably difficult due to medical condition, or medically inadvisable, to satisfy standard.
- Do not have to provide to everyone – just those who medically cannot meet standard. Can require doctor's certification.
- Do not have to decide alternative ahead of time – can take on case-by-case basis.
- Examples:
  - Reasonable alternative to stop smoking requirement – attend smoking cessation class.
  - Reasonable alternative to lower cholesterol requirement – require participant to follow doctor's advice.

Top 5 Wellness Questions:
What if we design our wellness program outside of our ERISA Plan?

- Example: Company will sponsor a "Biggest Loser" program, where employees voluntarily will weigh-in every week. Company will pay cash to the "biggest losers." The plan is not involved. To help employees lose weight, Company will provide one-on-one weight loss coaching.

- DOL has issued advisory opinions addressing EAPs that say if EAP provides individualized feedback or counseling by trained staff, program is an ERISA plan.

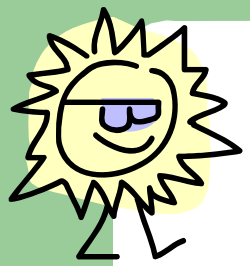
- So, if program provides individualized feedback, coaching, lab results, etc., may be considered an ERISA benefit subject to HIPAA rules (also must be part of plan document and SPD).

Top 5 Wellness Questions:
Does the ADA prohibit using a Health Risk Assessment?

- ADA prohibits “medical examinations and inquiries” unless voluntary. A Health Risk Assessment (“HRA”) may be considered a “medical examination and inquiry.”

- The EEOC has indicated that an employer may request information as part of a “voluntary” wellness program if the employer neither requires participation nor penalizes employees who do not participate.

- There also is an exception under the ADA for medical inquiries that are part of a “bona fide” plan, where the inquiry is not a subterfuge for discrimination.



New Proposed Cafeteria Plan Regulations

- The IRS re-proposed cafeteria plan regulations from 1984 and 1989 in an updated and expanded form (Aug. 2007).
- Once final, all requirements, including those that are restrictive or administratively burdensome, will be given high deference by a court.
- Public comment period is open now (comments due 11/5/07).

Effective Date

- The proposed effective date for these regulations is plan years beginning on or after January 1, 2009 for all provisions except:
  - **group-term life insurance (effective 8/6/07); and**
  - **debit card provisions (effective as described in previous IRS debit card guidance).**

New Written Plan Requirements

- A cafeteria plan must be in writing to satisfy Code section 125.
  - IRS regulations specify what information the written plan document must contain (e.g., description of benefits, election period, etc.).
  - NEW: Written plan requirements have expanded.
- If there is no written cafeteria plan, or if the written plan fails to satisfy any of the requirements, the plan is not a cafeteria plan and adverse tax consequences result.
- Written plan requirement under Code section 125 satisfies other Code sections.

Group Term Life Insurance

- Under Code section 79, an employer may provide up to $50,000 of group-term life insurance coverage on an employee without having to include any of the cost of that coverage in the employee's gross income.
- The cost of group-term life insurance coverage in excess of $50,000 must be included in the employee's income.
- The amount taxable to the employee is now based only on the cost of the excess coverage as determined under Table I of the regulations under Code section 79 (rather than the higher of the salary reduction amount or Table I rate).

Salary Reduction

- The new proposed regulations prohibit an employee from reducing qualified retirement plan distributions on a pre-tax basis to pay for qualified benefits under the cafeteria plan.
- The regulations do provide that severance payments may be reduced to pay for qualified benefits under the cafeteria plan on a pre-tax basis.
- No mention of long-term disability payments.
- Comments requested on whether salary reduction contributions may be based on employees' tips and how that would work.

Election Rules

- Cafeteria plan elections must be made before the earlier of the first day of the plan year (or period of coverage) or the date the taxable benefits would currently be available.
- NEW: The proposed rules contain an exception for new employees:
  - New employees may make elections between cash and qualified benefits within 30 days after their hire date.
  - The election is retroactive to the new hire date, and salary reductions for the election must be made from compensation not yet available on the date of the election.

Election Rules *(cont'd)*

- **NEW:** There is a new proposed rule that applies to HSAs:
  - **If a cafeteria plan offers HSA contributions as a qualified benefit, the plan must allow a participant to prospectively make, change or revoke salary contribution elections for HSA contributions before salary becomes currently available on at least a monthly basis.**
  - **Previous IRS guidance allowed an employer to adopt this rule, but did not require it.**

Flexible Spending Accounts

- **NEW:** Health, dependent care and adoption FSAs each can have separate periods of coverage, which are different than plan year, but must be for 12 months or entire short plan year.
- **NEW:** Employer may limit health FSA eligibility to employees who participate in one or more specified employer health benefits.
- **NEW:** Employer can specify any interval for employee FSA salary reduction, as long as uniform for all participants.
- **NEW:** Orthodontia – May reimburse advance payments if advance payments required to receive the services.

Nondiscrimination Rules

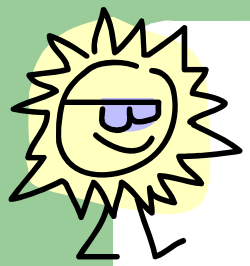
- The new proposed regulations provide more detail than the previous proposed regulations concerning how to determine whether a cafeteria plan complies with the nondiscrimination rules.
- More specific guidance and examples are critical in order to fully understand these requirements.
- The consequences of failing to satisfy these rules are:
  - the highly compensated participants must include in income an amount equal to the highest value of benefits he or she could have elected to receive under the discriminatory cafeteria plan.
  - If key employees elect more than 25% of the aggregate benefits elected by all employees under a cafeteria plan, key employees must include amounts that could have been elected in income.

Nondiscrimination Rules *(cont'd)*

- **The new proposed regulations provide two safe harbors from the non-discrimination rules.**
- **The first safe harbor is provided in the statute itself.**
  - **It is not clear how to apply this safe harbor, and the new proposed regulations do not provide any clarification or helpful examples.**
- **NEW: The second safe harbor, which is new, provides that premium only plans are also considered a safe harbor design if they pass the nondiscrimination test regarding eligibility.**
- **We will comment on this issue.**

Nondiscrimination Rules *(cont'd)*

- The new proposed regulations state that the actual operation of the plan must not discriminate in favor of highly compensated participants in operation.
- The new proposed regulations provide rules for aggregating and disaggregating cafeteria plans for purposes of determining whether the plan is discriminatory.
- The new proposed regulations provide that the nondiscrimination tests must be conducted annually as of the last day of the plan year and must include any non-excludible employees who were employees at any time during the year.
- We will comment on these issues.



The State of State Health Care Reform

Reform is happening and it's happening at ALL levels of government:

- Federal (Seeking more state flexibility)
- State
- County
- City

Types of State Health Care Reform

- Pay or Play/ Fair Share
- Health Care Access & Insurance Reform
- Other:
  - TPA Tax
  - Fair Wage Acts
  - Cafeteria Plan Mandates
  - Dependant Coverage Expansion
  - Electronic Submission of Health Transactions

Pay or Play / Fair Share Laws

- Reform effort started by AFL-CIO.
- Bills introduced in over 33 states.
- Requires large employers to pay a set dollar amount or certain percentage of payroll for health care or pay a penalty to the state.

ERISA Preemption

States are:

1. Proposing moderate legislation and hoping its not challenged,
2. Requesting federal ERISA waivers &
3. Attempting to legislate around ERISA.

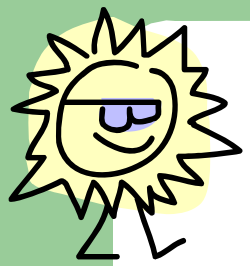
Health Care Reform Through Cafeteria Plan Mandates

- Cafeteria Plan Mandates
  - Requires employers to provide a cafeteria plan through which all employees may make pre-tax payments for health coverage.
  - Copies Massachusetts mandate (eff. Oct. 2007)
  - Cafeteria Plans are not ERISA plans
  - Adopted in:
    - Rhode Island (eff. January 2009)
    - Connecticut (eff. October 2007)
    - Missouri (eff. January 2008)

Health Care Access & Insurance Reform

Partial list of states proposing access and insurance reform in 2007:

- **Massachusetts**
- **Vermont**
- **Pennsylvania**
- **California**
- **Illinois**
- **New York**
- **New Jersey**
- **Wisconsin**
- **Tennessee**
- **Indiana**
- **Colorado**
- **Washington**



Latest on Massachusetts Health Care Reform

- Effective: July 1, 2007.
- Generally applies to employers with 11 or more employees in Massachusetts.
- More information / forms at: www.MAHealthConnector.org.
- Individual Mandate - Massachusetts residents must purchase health insurance by July 1, 2007, or lose personal tax exemption and be subject to monetary penalties.
- Employer Responsibilities – Cafeteria Plan, Fair Share, HIRD Reporting, Minimum Creditable Coverage Notices.

Massachusetts Health Care Reform
Cafeteria Plan Requirement

- Employer must have cafeteria plan that covers all employees who work at least 64 hours per month (or 16 hours per week).
- Not required to provide health coverage, but must allow employee to pay for whatever coverage they have on pre-tax basis through cafeteria plan (this includes coverage through Massachusetts Connector Program).
- Under new bulletin issued 9/5/07, employer no longer required to "file" cafeteria plan document, but must provide to Commonwealth within 7 days upon request.

Massachusetts Health Care Reform
Fair Share Contribution (FSC)

- Employer must make a “fair and reasonable premium contribution” or pay annual “fair share” employer contribution to Commonwealth (of up to $295 per employee per year).
- Employer premiums considered “fair and reasonable” if:
  - At least 25% of full-time employees enrolled in employer plan (and employer contributes any amount); or
  - Employer contributes at least 33% of premium.

Massachusetts Health Care Reform
Employer HIRD / FSC Filing

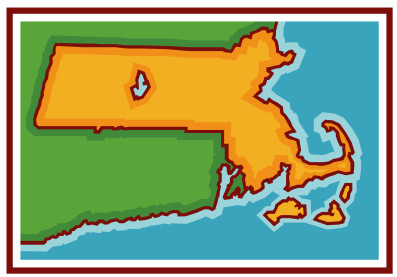
- Employers required to complete combined FSC / HIRD filing by 11/15/07.
- Previously, these were two filings, but now are combined and are to be filed online (form and instructions now available online).
- FSC filing will ask information to determine whether employer has 25% participation or makes 33% contribution.
- HIRD filing will ask census information, such as number of employees, premium amounts, and whether employer has cafeteria plan.

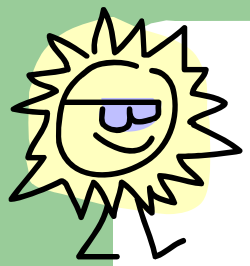
Massachusetts Health Care Reform *Employee HIRD Form*

- Employer must collect Employee HIRD form from Massachusetts employees who declines employer coverage or cafeteria plan participation. Form available online.
- Employer not required to file forms, but must retain for 3 years and provide to Commonwealth upon request (also provide signed copy to employee).
- Form relates to employees without coverage as of July 1st and must be signed by earlier of September 30th or 30 days after Open Enrollment. New hires must sign within 30 days of end of enrollment period.

Massachusetts Health Care Reform
Minimum Creditable Coverage Notice

- Employer required to provide certificate of creditable coverage (or 1099-HC form) to employees by January 31st of each year notifying them whether employer coverage is "creditable."
- For 2008, all employer coverage deemed creditable, so not clear whether MCC notice must be provided for 2008.
- Commonwealth has issued a draft 1099-HC form, but has noted that it is subject to change.





Questions?