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■ From the Editor

When all is said and done, the most important benefits are those relating to health care. As has been said many times, without your health, you have nothing.

Articles in this month's "Focus" section report on a variety of health care issues important to employers and their employees.

WELLNESS PROGRAMS

The first article in our "Focus" section is entitled "Is Your Incentive Strategy Sound? Guidelines for Designing a HIPAA Compliant Wellness Program." Here, Greg Barry and Jessica Grossmeier examine a hypothetical company and explore how to develop a wellness program and incentives to encourage participation in the program.

RENEWALS

In the current environment, companies and their consultants across the country are making sure they are spending exactly what should, and not a dollar more, for health care.

Their goal is to make sure "the market" is efficient.

John Flaherty, a senior vice president with Longfellow Benefits in Boston discusses these issues in his article, "An Efficient Approach to Managing Health Care Renewals."

AND MORE...

We have numerous other articles and columns in this issue, including a special report by Marjorie M. Glover and Rachel M. Kurth of Chadbourne & Parke LLP on the "New COBRA Subsidy Requirements" contained in the sweeping economic stimulus legislation known as the American Recovery and Reinvestment Act of 2009, and a Pharmacy Benefits column on strategies to help stretch pharmacy benefit dollars by Heidi C. Lew, vice president of clinical programs for Prescription Solutions.

Enjoy the issue!

Steven A. Meyerowitz
Editor-in-Chief
July 2009

Questions may be directed to Employee Benefit Plan Review, 10 Crinkle Court, Northport, NY 11768, or via e-mail to smeyerow@optonline.net. Answers by the benefits experts at Spencer's Benefits Reports will be included in an upcoming issue.

REQUIRING PARTICIPATION IN WELLNESS PROGRAMS MAY VIOLATE ADA

Q May a health care plan be amended to allow separate reimbursements (or different amounts of reimbursement) for members who comply with certain preventive health measures such as yearly physicals and wellness visits?

A The Health Insurance Portability and Accountability Act (HIPAA) prohibits discrimination in health care coverage. However, these nondiscrimination provisions do not prevent a plan or issuer from establishing discounts, rebates, or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

There are many wellness programs to promote health and prevent disease, and under HIPAA "wellness programs" need not be labeled as such and may include a program that reduces an individual's cost-sharing for complying with a preventive care plan; a diagnostic testing program for health problems; and rewards for attending educational classes, and following healthy lifestyle recommendations.

If a wellness-type program provides a reward, such as a premium discount or waiver of a cost-sharing requirement, based on participation in a program of health promotion or disease prevention, the program does not violate the HIPAA nondiscrimination provisions even if it does not satisfy the requirements under a wellness program.

However, the Equal Employment Opportunity Commission (EEOC) recently sent a discussion letter stating that requiring completion of a health risk assessment as a condition for participation in a health benefit plan is a violation of the Americans with Disabilities Act.

While HIPAA under certain circumstances might allow requiring participants to complete a health risk assessment (HRA) as a condition for participation in the employer's health care plan, the Americans with Disability Act (ADA) would prohibit such a requirement unless the HRA or medical questionnaire was job-related, according to a March 6, 2009, letter from the EEOC's Office of Legal Counsel staff members.

In its letter, the EEOC Legal Counsel's Office asserted that it was only an informal discussion of the issues raised in a request for comment and "does not constitute an official opinion" of the EEOC.

Requiring that all employees take an HRA that includes disability-related inquiries and medical examinations as a prerequisite for obtaining health insurance coverage does not appear to be job-related and consistent with business necessity, and therefore would violate the ADA. Disability-related inquiries and medical examinations also are permitted as part of a voluntary wellness program. A wellness program is voluntary if employees are neither required to participate nor penalized for non-participation.

A copy of the EEOC letter is available at http://www.eeoc.gov/foia/letters/2009/ada_disability_medexam_healthrisk.html.

REQUIRING SPOUSAL CONSENT

Q Does a retirement plan that is not subject to the qualified joint and survivor annuity (QJSA) rules have to receive spousal consent on distributions in excess of \$5,000?

A If the plan is not subject to the QJSA or qualified preretirement survivor annuity rules, then, under IRC Section 417(e)(1), spousal consent is not required for the distribution.

HSA CONTRIBUTION, DISTRIBUTION DIFFERENCES

Q A husband has health coverage under his wife's plan. The individual has also elected to participate as of January 2009 in his employer's health care flexible spending account and elected to defer \$4,000 of earnings. By April 2009, the husband claimed \$1,500 in reimbursement under the FSA. On June 1, the wife's health plan changed to a high deductible health plan with an HSA.

How is the wife's HSA and the husband's FSA affected? Who can contribute to an HSA? Must the husband discontinue participation in the FSA? How are reimbursements handled through the HSA and the FSA?

A The wife may establish and contribute to an HSA, but the individual may not.

If a spouse has HDHP family coverage and the other spouse has non-HDHP self-only

■ Ask the Expert

coverage (such as an FSA), the spouse with the HDHP family coverage is an eligible individual and may contribute to an HSA up to the amount of the annual contribution limit (the family deductible). Because the other spouse is covered by a non-HDHP and is therefore not an eligible individual, the other spouse may not contribute to an HSA.

As noted in IRS Notice 2004-02, Q&A 25&26,

Distributions from an HSA used exclusively to pay for qualified medical expenses of the account beneficiary, his or her spouse, or dependents are excludable from gross income. In general, amounts in an HSA can be used for qualified medical expenses and will be excludable from gross income even if the individual is not currently eligible for contributions to the HSA....

The term “qualified medical expenses” are expenses paid by the account beneficiary, his or her spouse or dependents for medical care as defined in section 213(d) (including

nonprescription drugs as described in Rev. Rul. 2003-102, 2003-38 I.R.B. 559), but only to the extent the expenses are not covered by insurance or otherwise. The qualified medical expenses must be incurred only after the HSA has been established. For purposes of determining the itemized deduction for medical expenses, medical expenses paid or reimbursed by distributions from an HSA are not treated as expenses paid for medical care under section 213.

Keep in mind that the rules for contributing to an HSA are not linked to the rules for HSA distributions. Only those with HDHP coverage only may establish and contribute to an HSA. However, funds from an HSA may be used for any qualified unreimbursed medical expenses.

In the example provided, without some status, cost, or coverage change under Section 125, the FSA holder (the husband) must continue FSA contributions through the end of the plan year, and he may continue to be reimbursed under

the FSA for unreimbursed medical expenses.

CALCULATING COBRA SUBSIDIES

Q Is the 65 percent COBRA employer subsidy reimbursement under the American Recovery and Reinvestment Act of 2009 based on the active premium or the 102 percent COBRA premium?

A Both the 35 percent and the 65 percent calculations are based on the same amount, the COBRA premium that is payable by the beneficiary.

As noted in IRS Notice 2009-27, individuals must pay 35 percent of the “premium otherwise payable for COBRA continuation coverage.” In turn, the employer may be reimbursed for the other 65 percent of the premium “that is not paid by the assistance eligible employee.”

For example, an employer requires individuals electing COBRA continuation coverage to pay \$500 per month. An assistance-eligible individual is entitled to COBRA continuation coverage upon the timely payment of \$175 (35 percent of \$500). The employer’s resulting payroll tax credit is \$325 (65 percent of \$500). ❁

Is Your Incentive Strategy Sound? Guidelines for Designing a HIPAA Compliant Wellness Program

GREG BARRY AND JESSICA GROSSMEIER

Employees at J. Doe Tool & Die (J. Doe) were cautiously receptive when management initiated a wellness program for their 7,200 employees. The program included a health assessment and targeted follow-up health coaching programs for individuals with identified health risks, as well as online health information and a wide range of tools and activities available to all interested employees. The wellness program and incentives to encourage participation were being managed by a third party vendor. The company was among a growing number of employers that offer incentives for completion of a health assessment or involvement in a wellness program. In fact, a recent survey showed that more than 70 percent of employers now offer some type of incentive for participation in health management programs.¹

J. Doe Tool & Die initially offered a \$120 gift card to employees who completed a health assessment. They backed this up with a strong communications plan and initiated a strategy to create a culture of health within the company by sending a communication from the CEO to all employees encouraging their participation and holding a kick-off event where company leaders visibly participated themselves. The result was an impressive health assessment completion rate of 65 percent for the company's first year of program launch.

After reviewing data from the health assessment, management discovered that employee obesity was responsible for a disproportionate amount of the company's health risks and health-related costs and was much higher than national norms.

In an effort to address this high-priority health risk in year two, J. Doe management came up with a new incentive strategy, but they failed to consider one very important aspect: the Health Insurance Portability and Accountability Act (HIPAA).

J. Doe's strategy in year two was to offer a \$120 health insurance premium reduction to employees who completed the health assessment and had a BMI of less than 30. Meanwhile, employees completing the

assessment who had a BMI of 30 or higher received only a \$60 health insurance premium reduction, with no other opportunity to earn the additional amount.

Not long after implementing this plan, the human resources department began receiving angry phone calls from employees whose BMI was 30 or greater. They claimed they were being discriminated against and that they should be eligible to earn the same incentive as other employees if, for example, they completed a behavior change program to manage their weight. They were right. Decision makers at J. Doe Tool & Die had committed a serious HIPAA violation because they treated similarly situated individuals differently based on a health factor. Specifically, they offered an incentive to employees for satisfying a standard related to a health factor without considering the requirements of the HIPAA Nondiscrimination Rule.

WHAT IS HIPAA AND WHY DOES IT MATTER?

HIPAA was enacted in 1996 as a way to protect individual health information, to protect individuals as they change health coverage between employers, and to prevent health insurance fraud and abuse. HIPAA also affects companies, like J. Doe, that sponsor employee health plans. While HIPAA is widely known to regulate the sharing of data between health care companies, it also contains provisions regarding nondiscrimination in insurance and wellness programs.

J. Doe would have benefited by learning about an important section of the HIPAA regulations, known as the Nondiscrimination Rule, which generally prohibits employer health plan sponsors and other health care companies from discriminating against individuals based on their health status. This means an incentive program must either treat all similarly situated individuals the same or be structured in such a way so as to ensure that the incentive offering is not discriminatory. In a case like that of J. Doe Tool & Die, if a program is found to be non-compliant, the employer may be asked to

submit a plan for correcting the situation and could incur other penalties.

FIVE REQUIREMENTS FOR A HIPAA COMPLIANT WELLNESS PROGRAM WITH INCENTIVES BASED ON A HEALTH FACTOR

To avoid making a mistake like J. Doe did, one must understand the regulations. First, determine whether the incentives are given simply for program participation. If so, the incentive structure is inherently non-discriminatory and no restructuring is necessary. However, if the incentive is based on an individual satisfying a standard related to a health factor, then the incentive structure is discriminatory *unless* it meets the following five requirements specified in HIPAA:

1. The reward value must not exceed 20 percent of the total cost of coverage under the plan;
2. The program must be “reasonably designed” to promote good health or prevent disease, without being overly burdensome or intentionally designed to discriminate against certain people;
3. Individual employees must have a chance to qualify for the reward at least once a year for as long as the health factor is required to earn the reward;
4. The reward must be available to all similarly situated individuals through the allowance of reasonable alternative standards to qualify for the reward. This means that employees must be offered a reasonable alternative to qualify for the reward if they cannot achieve a certain standard based on an individual health factor because it would be unreasonably difficult or medically inadvisable due to a medical condition. Options include a physician release with alternative goals or the option to participate in a behavior change program targeted to the specific health factor; and
5. All material describing the wellness program (as opposed to

merely mentioning the program availability) must disclose the availability of reasonable alternative standards. The availability of a reasonable alternative must be disclosed in all plan materials describing the program; however, the particular alternative need not be described.

USING INCENTIVES AFTER THE HEALTH ASSESSMENT

While incentives have proven to be effective at capturing people’s attention, a company cannot rely on incentives alone to achieve its health management goals or create long-term behavior change.

Incentives can encourage employees to take the first step toward a healthier lifestyle—such as completing an annual health assessment or completing a follow-up risk reduction program—but research indicates that, to create lasting change, individuals must ultimately find motivation from within themselves. It is still unclear how long incentives can maintain change in the absence of such commitment.

Maintaining engagement and motivation over time is also a challenge for many companies offering health management programs. If your company has had success with incentives but still is not seeing the desired long-term results, assess the health management program to make sure that everything that can be done is being done to support employees who are trying to make healthy behavior changes. This may include everything from evaluating the workplace culture, to analyzing the specific programs being offered.

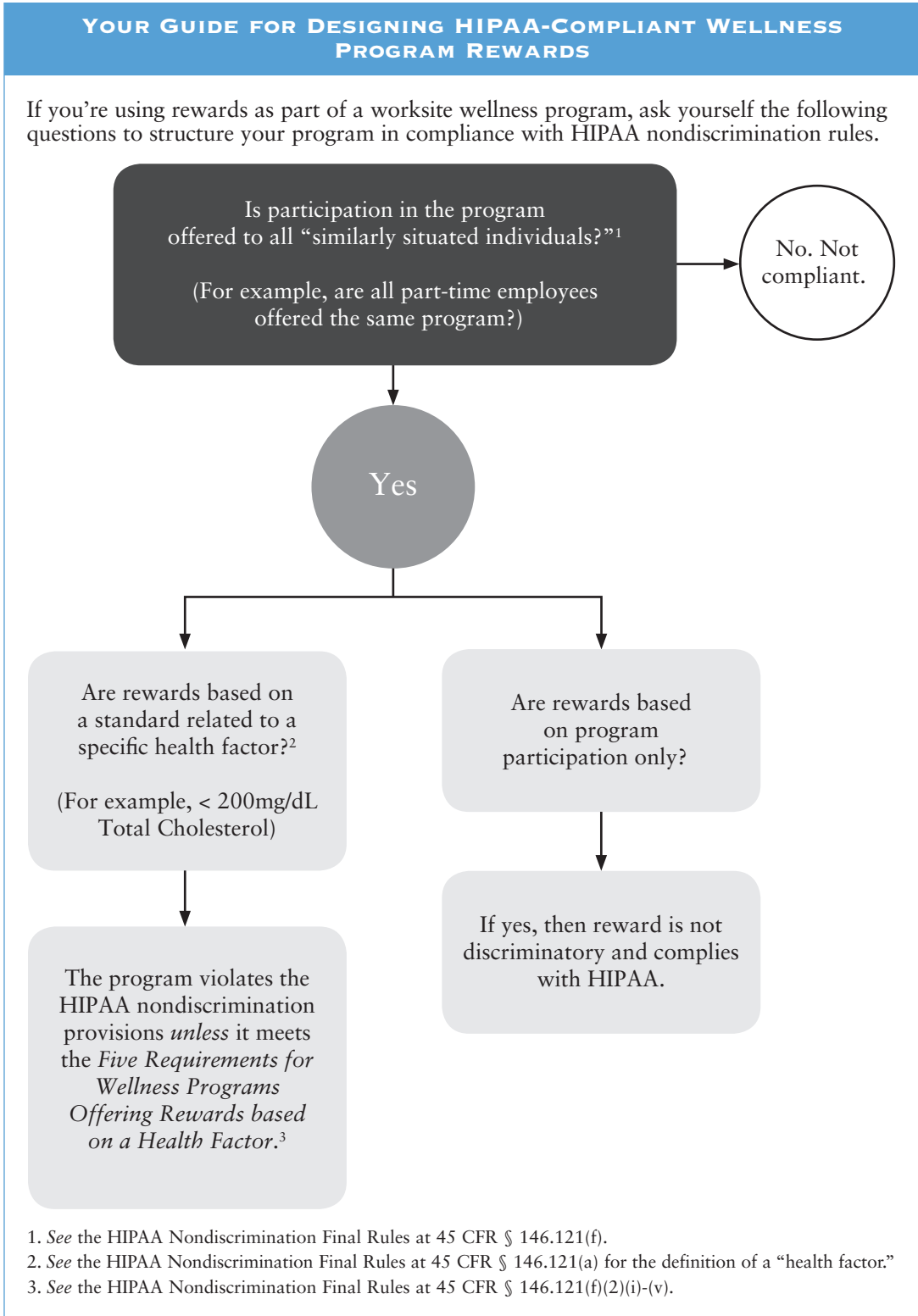
As an incentive strategy evolves, it is important to test the plan against the HIPAA regulations and guidelines to ensure that it is in compliance with the law. Once a strategy passes this test, the following guidelines will improve the effectiveness of the incentive strategy beyond the health assessment.²

- *Keep it simple*—Your incentive strategy does not have to be

complex or extravagant. In fact, the simpler, the better.

- *Make it meaningful*—Employees are more likely to enroll in a program if the incentive is relevant to them and their needs.
- *Incent for follow-up*—To garner more long-term program success, think about how you can apply incentives beyond the health assessment. For instance, consider offering an incentive for completing a health coaching program. Our experience shows that health coaching can have a significant impact on people with elevated health risks as well as those with chronic conditions.
- *Remember the “Goldilocks Principle”*—When it comes to follow-up program incentives, research is consistent with a large body of behavioral science literature suggesting the incentive should be just big enough to “tip the balance” toward participating without becoming the primary reason for participating. Sustaining long-term change ultimately requires internal commitment; the incentive is just a catalyst to help accelerate the process for those already thinking about change.
- *Communicate clearly*—Employees need information and reminders about what is available and how to participate.
- *Make tracking visible*—Make it easy for employees to see if they have earned the incentive and to track progress toward their goals.
- *Keep it manageable*—The program must be easy to understand and easy to administer for your staff to ensure program success.
- *Do not rely on incentives alone*—Incentives can be effective but they do not take the place of senior leadership support, solid communication strategies, or a supportive culture when it comes to driving and sustaining employee participation in programs.

Research has shown that companies that achieve the greatest,



long-term results with their health management programs follow certain best practices for a comprehensive approach to wellness.³ So what makes these companies successful?

For starters, they pursue every opportunity to integrate health into the culture of their workplaces. In addition, they follow a set of health management best practices that have

been shown to generate positive results. Those best practices include:

- Visible, strong senior management support;

■ Focus On...

- A comprehensive program design;
- Incentives integrated into the health plan design;
- Consistent and ongoing employee communication;
- Dedicated onsite staff wherever feasible;
- Multiple program delivery methods (phone, mail, online) offering employees choices that match their needs and preferences;
- Population-based awareness-building activities;
- Biometric health screenings where cost-effective; and
- Integration of health-related initiatives wherever it adds value.

After realizing the inequity of its existing incentive strategy, in an effort to voluntarily comply with the HIPAA regulations, J. Doe Tool &

Die adjusted its incentive strategy. The company directed its incentive management vendor to distribute an additional \$60 premium reduction to participants who had originally been discriminated against based on their failure to meet a specified health factor. To prevent future HIPAA related mistakes, J. Doe Tool & Die established an internal HIPAA team to design strategic policies and procedures, and a review board to ensure strict compliance with HIPAA regulations in the future. ♻️

NOTES

1. IncentOne 2008.
2. "The Role of Incentive Design, Incentive Value, Communications Strategy, and Worksite Culture on Health Risk Assessment Participation," Erin L. D. Seaverson, MPH; Jessica Grossmeier, MPH; Toni M. Miller; and David R. Anderson, PhD, *American Journal of Health Promotion*, May/June 2009.
3. "Association Between Nine Quality Components and Superior Worksite Health Management Program Results," Paul E. Terry, PhD; Erin L. D. Seaverson, MPH; Jessica Grossmeier, MPH; and David R. Anderson, PhD, *Journal of Occupational and Environmental Medicine*, May 2008.

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An Efficient Approach to Managing Health Care Renewals

JOHN FLAHERTY

In the current environment, companies and their consultants across the country are making sure they are spending exactly what they should, and not a dollar more, for health care. Their goal is to make sure “the market” is efficient.

THE EFFICIENT MARKET HYPOTHESIS

The Efficient Market Hypothesis says that a company’s stock price reflects all available information known to the market. When obtaining health insurance quotes for a company, one of the consultant’s main goals is to confirm that the market *is* efficient and the client is obtaining maximum value. More than 10 years ago, it did not always make sense to obtain new health care quotes year after year. Insurance carriers’ underwriting departments would label a company as one that was not interested in partnering, and the company would be known as a “hopper” bouncing from carrier to carrier trying to save along the way looking for the best deal. Insurance carriers did not approve of this approach, because they felt it cut into their profits in the long run.

Annual marketing of a company’s health care plan is a common occurrence. Companies still receive value from this approach, sometimes saving enough (usually in the four percent to eight percent range) to move to a different carrier, with the new carrier offering the same product, plan design, and provider network. This is relatively common as a fair amount of companies across the country switch carriers every year.

But why do companies switch carriers so often? Does the market dramatically change that much over a 12-month period? Are insurance carriers charging companies too much even though the analysis was done during the past 12 months? Or, is there a certain amount of inefficiency that exists in each business, including all insurance companies? Is it possible that over time efficiencies increase and insurance companies are able to bring that value to the client, hence

offering a better deal and savings? Following is a step-by-step overview of a “blocking and tackling” approach taken to ensure the health care market is efficient and maximum value is achieved upon renewal. The following steps are intended for companies usually with more than 100 covered employees and operating under a fully insured financial arrangement.

A STEP-BY-STEP GUIDE TO GETTING MAXIMUM VALUE WHEN RENEWING HEALTH CARE PLANS

Step One

The employer should meet early in the new year with their employee benefit consultant for a strategy session. This session should be viewed as an important meeting that will set the tone for the upcoming year’s renewal. Every company is at a particular point on the health care continuum. It is important the company and their consultant understand and agree where that point on the continuum is and where the company wants to go. Many variables determine whether a company wants to move along this sensitive and ever-changing continuum, such as:

- The state of the economy;
- Strength of company’s industry;
- Strength of company’s financials;
- Senior management’s adversity to risk; and/or
- The company’s corporate culture.

A company could be at one end of the continuum where it has an above-average product/plan design and an above-average employee contribution. Is this where the company wants to be? Do the employees at the company value and understand the medical plan’s richness? Are the employees aware that the company is paying the majority of this expense? If this is not conveyed to the employees or it is not valued by the employees, it could be viewed as being over insured and, possibly, as wasting corporate assets.

Step Two

Health care plans are marketed, based upon the company's current product and plan design. This step will determine if there are any inequities in the market. For example, if a medical carrier is interested in underwriting the same risk with the same product and plan design that currently exists. Approximately 30 percent to 40 percent of the time a stronger, more financially aggressive alternative becomes available, with savings that may be compelling enough for the company to consider switching health carriers. Some reasons why such inequities may exist include:

- A lower cost and utilization trend is used by an insurance carrier. The carrier may have found an improved way of aggressively managing medical trend, defined as the year-over-year increase in the cost and utilization of medical services. In the current market, an approximate two percent to three percent trend variance is present.
- A lower retention factor may be used. For every dollar that a medical insurance carrier collects, it desires to pay out 85 cents (on average) in claims, retaining 15 cents, or 15 percent, to cover administration charges and add a contribution to reserves. For-profit, publicly traded insurance carriers on average require a retention charge closer to 18 percent, while nonprofits are looking for 13 percent to 14 percent. It is not uncommon to see an aggressive 10 percent to 11 percent in some markets.
- Industry adjustment. The medical carrier may be attracted to certain industries and offer aggressive pricing. This could be based upon the carrier's profitability margin within that particular industry.
- Credibility adjustment (for companies with more than 100 employees on their plan).

A company's claim estimate is calculated using a percentage (between

zero percent and 100 percent) of the company's own claims experience or history and a percent (the complement) of the insurance carrier's manual claim estimate (the community rate adjusted for similar industry and demographics of the company). The underwriter at the medical carrier may assign a higher percentage of the company's claims experience as compared to the manual. In some instances, this has generated a favorable rate variance in the range of two percent to four percent.

Step Three

After the carrier has provided rates for the current product and plan design and an "apples to apples" comparison can be made, next it makes sense to ask for *different* plan design options, specifically involving deductibles. When deductibles are added to a medical plan, the rate decreases, but the rate decrement differs from one carrier to the next, at times creating up to an eight percent variance. Deductible plans are just getting past their infancy stage in the market and insurance carriers have different experience and different profitability formulas with such plans, hence the reason such disparities exist. If a company decides to analyze a deductible plan in conjunction with a health reimbursement account (HRA) or a health savings account (HSA), the disparity among carriers increases again. This is mainly due to the utilization adjustment a medical carrier may or may not give on a particular quote. Year Two renewals might provide a lower medical trend on the HRA or HSA plan as compared to a nonconsumer-driven health care plan. If these adjustments are applied, another percentage or two could be alleviated from the renewal calculation.

ANOTHER IMPORTANT CONSIDERATION— COMMUNICATION— INTEGRATION

After the current year's renewal is completed it would be beneficial

to implement an employee communications plan for the coming year. The goal is to inform employees throughout the year about employee benefit information that is relevant to their own plans, as well as to keep them apprised of developments in employee benefits and the health care industry. This company-specific communication would act as an aid to inform the employees how to best use the plan throughout the year, and educate them on the particulars.

The macro-view perspective will allow the company to inform the employees about what is taking place in the industry. This communication would complement what the employees are reading in other media on employee benefit and health care topics.

One of the most important benefits of the communication campaign would be realized when the company decides to, or must, change health care carriers, products, plan design, employee contribution, and/or institutes a consumer-driven health care strategy. The employees will already be aware of the options and industry trends, making it less likely they will make a hasty, uninformed decision during open-enrollment period. Having the requisite knowledge will make any plan transition easier for the employees. Communication and ongoing education are key to enlightening employees to the fact that health care choices are becoming increasingly complex, and costly, and must be considered as a larger part of their financial planning.

CONCLUSION

The steps mentioned above create a process that, if followed, will help ensure efficient market operations, and will provide clients with all available health care information, and bids from carriers who are willing to underwrite their business. This process combined with a consultant's ability to be creative and to diligently push their team to *understand* the customer,

To Your Health!

their employees, their culture, their business, and their environment, will lead to the selection of the most efficient plan and the greatest savings. This is the best tactical

approach to managing a health care policy renewal. The employer will be satisfied that they are receiving maximum value and the market is, indeed, efficient. 🌟

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Employees Covered Under Spin-Off's Benefit Plan Cannot File ERISA Suit Against Original Business Entity, Circuit Court Rules

The plaintiffs in this case worked for the AT&T Corporation until retiring, when they began to receive post-retirement benefits under the AT&T Management Pension Plan. After they retired, AT&T spun off a new corporate entity, Lucent Technologies Inc., and transferred the plaintiffs to a Lucent-sponsored retirement benefits plan. For several years, the plaintiffs received the same benefits from the Lucent plan as they had received under the AT&T plan. Thereafter, Lucent eliminated certain benefits, and the plaintiffs brought suit against AT&T, asserting claims under ERISA Section 502(a)(1). The district court granted summary judgment to AT&T, holding that the plaintiffs could not sue AT&T under this section of ERISA because they were no longer participants in the AT&T benefits plan. The plaintiffs appealed to the U.S. Court of Appeals for the Tenth Circuit.

In its decision, the Tenth Circuit ruled that when a business entity creates a spin-off and transfers an employee benefits plan to the spin-off, employees covered under the spinoff's plan cannot file suit against the original business entity under Section 502(a)(1) of ERISA, which allows civil suits by a participant of an ERISA plan "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." The appellate court explained that those employees were not owed benefits by their original employer, and thus they did not have a "colorable claim to vested benefits" under the original entity's plan. Rather, if plaintiffs had any colorable claim to benefits under Section 502(a)(1), it would have been against Lucent, not against AT&T. Therefore, it concluded, the plaintiffs in this case were not "participants" in the AT&T benefits plan and could not sue AT&T under Section 502(a)(1). Accordingly, the Tenth Circuit affirmed the district court's grant of summary judgment to AT&T. [*Chastain v. AT&T*, 558 F.3d 1177 (10th Cir. 2009).]

Claim That Plant Was Closed to Interfere with Retirement Benefits Is Rejected

TRW Automotive U.S. LLC, an indirect subsidiary of TRW Automotive Holdings Corporation, owned and operated the Van Dyke plant, where the plaintiffs worked. Van Dyke, a 370,000 square foot facility, was part of TRW's North American Braking and Suspension Group; workers there manufactured front suspension components for various car makers. Its employees, represented by the United Auto Workers, were covered by a collective bargaining agreement between TRW and the UAW, and a defined pension plan.

TRW claimed that, as of 2004, it faced overcapacity problems that hampered profits. In response, it organized a group to research the costs and benefits of shutting down some of its North American plants. That group identified the Van Dyke plant as a prime candidate for closure. Before making that decision, TRW considered a few alternatives, including placing work for DaimlerChrysler at Van Dyke. Ultimately, however, the company decided that Van Dyke was in fact not the right place for that work, and the DaimlerChrysler work wound up at a plant located on Mancini Drive owned by a separate subsidiary of TRW Holdings.

Shortly before TRW shut Van Dyke down, it discussed with the UAW the possibility of preferentially hiring laid off Van Dyke employees at the Mancini plant and "bridging" the benefits of Van Dyke employees who were close to vesting. TRW also offered severance to employees who opted out of their available retiree benefits. The two sides, however, failed to reach an agreement and TRW closed Van Dyke. At that time, three employees missed retirement eligibility by less than one year of benefit service and four others missed retirement eligibility by less than two years.

Former Van Dyke employees sued, alleging that TRW violated Section 510 of ERISA, which makes it “unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under [an employee benefit plan].” In particular, the plaintiffs argued that TRW violated ERISA by: (1) failing to recall employees following a layoff; (2) refusing to transfer employees to the Mancini Drive facility; and (3) improperly discharging employees to interfere with their attainment of retirement eligibility. The district court granted summary judgment to TRW on all counts, and the plaintiffs appealed.

The U.S. Court of Appeals for the Sixth Circuit explained that, to defeat summary judgment, the plaintiffs had to show that TRW fired them for the purpose of interfering with the attainment of their retirement benefits. The appellate court found that the plaintiffs had satisfied the “low-threshold” for establishing their prima facie case: a TRW vice president had stated that pension costs—colloquially known within the company as “legacy” or “heritage” costs—were among the reasons to close down the plant, and, as the district court had observed, the work done at Van Dyke was transferred to a nonunion facility where such costs “were reduced or nonexistent.”

The Sixth Circuit then found that, in response to the plaintiff’s prima facie case, TRW had made an evidentiary showing of a nondiscriminatory reason for closing Van Dyke: only 30,000 square feet of its available 300,000 square feet was being used, so roughly 26 percent of every sales dollar went to fixed costs and overhead.

As the Sixth Circuit pointed out, the next part of the analysis was whether TRW’s reason was a “pretext.” The plaintiffs argued

that TRW’s proffered reason was phony because the plant was so poorly run; specifically, that the company could have kept Van Dyke going if it had cut a variety of possible costs and placed the DaimlerChrysler work there. Thus, the plaintiffs argued, because TRW did not do those things, it must have been the company’s desire to interfere with their pension benefits that motivated it to close their plant.

The circuit court declared that the issue was whether reducing pension benefits by shutting down a plant with employees close to vesting was a “motivating factor” or was instead “incidental” because there were other, neutral, business reasons at play. It then stated that it could not find that TRW’s reason was a mere pretext. The Sixth Circuit explained that when the plant was shut down and the employees laid off, only three employees were within a year of reaching eligibility, while another four were roughly two years away; a majority of the Van Dyke employees needed more than five more years for their benefits to fully vest. Moreover, two of the employees that TRW did recall—which was done on the basis of seniority per the bargaining agreement—established their benefits eligibility while working at the Mancini plant. According to the Sixth Circuit, this undercut the plaintiffs’ claim.

The Sixth Circuit stated that when plants were shut down, there would necessarily be a variety of factors at play beyond how close certain employees might be to vesting, and thus plaintiffs had a lot to wade through to establish liability. The appellate court concluded that Section 510 plaintiffs did not need “smoking gun” evidence, but did need more than the plaintiffs had in this case. Accordingly, it affirmed the district court’s grant of summary judgment to TRW. [Crawford v. TRW Automotive U.S. LLC, 560 F.3d 607 (6th Cir. 2009).]

Court Rejects Suit Seeking Attorney’s Fees Incurred During “Claim Reassessment Process”

In response to the plaintiff’s claim for disability benefits under a long term disability policy issued by UNUM Life Insurance Company of America, UNUM determined that the plaintiff was disabled, but that benefits due her under the policy were limited to 24 months of payments because her disability was based on self-reported symptoms of a mental or nervous condition. The plaintiff appealed UNUM’s determination through UNUM’s internal appeals process, but UNUM adhered to its original decision.

The plaintiff filed a complaint in a federal district court against UNUM, alleging that UNUM had wrongfully limited the term of disability benefits to which she was due. The complaint contained a claim for attorney’s fees and costs as authorized by ERISA.

Before the plaintiff sued UNUM, UNUM and several other disability insurance companies entered into a settlement agreement with the U.S. Department of Labor and the insurance regulators of 49 states. As a part of that settlement agreement, UNUM was required to offer claimants—including the plaintiff in this case—the opportunity to have their claims revisited through a claim reassessment process. In that process, the insurer would conduct a review of the original claim and any additional information provided to the insurer by the claimant to determine whether the original claim decision was proper.

Shortly after the plaintiff filed her complaint, she received a letter from UNUM offering her the option of pursuing her claim through the

claim reassessment process. The plaintiff agreed to have her claim revisited in the claim reassessment process, and the district court stayed the litigation. The plaintiff's lawyers represented her in the claim reassessment process, marshaling facts and legal theories relevant to her claim and communicating with UNUM on her behalf.

As a result of the claim reassessment process, UNUM agreed to reinstate payment of the plaintiff's benefits retroactively. All of the plaintiff's claims against UNUM, with the exception of her claim for attorney's fees and costs, were resolved. The plaintiff voluntarily dismissed all of the resolved claims but asked the district court for an award of all attorney's fees and costs she had incurred.

A magistrate judge initially considered the plaintiff's motion. The magistrate judge recommended that the motion be granted in part and denied in part. The magistrate judge recommended that the plaintiff receive fees and costs for the work done in the litigation (prior to the stay) but found that the plaintiff should not recover fees and costs for the work done in the claim reassessment process (during the stay). The magistrate judge also recommended awarding fees and costs for preparation of the motion seeking fees and costs (after the stay was lifted) but found that the number of hours expended was unreasonable and therefore recommended limiting the number of hours for which fees would be awarded. The district court adopted the magistrate judge's report and recommendation and entered judgment for the plaintiff in the amount of \$8,688.50. The plaintiff appealed to the U.S. Court of Appeals for the Eleventh Circuit.

On appeal, the plaintiff argued that she was entitled to attorney's fees and costs for all of her attorney's work on the matter, including the work done in the claim reassessment process and all of the

time claimed for preparation of the motion for attorney's fees and costs. She argued that the district court had erred in holding that ERISA did not authorize recovery of fees for the claim reassessment process.

UNUM defended the judgment, arguing that the district court had not abused its discretion in limiting the award because fees and costs awarded under ERISA were limited to those fees and costs incurred in an action before a court, and the claim reassessment process was not part of such an action. UNUM also argued that the district court had not abused its discretion in limiting the fees and costs awarded for work on the motion for attorney's fees and costs.

The Eleventh Circuit first noted that the statutory provision under which the plaintiff claimed entitlement to attorney's fees and costs stated:

In any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

The circuit court then added that by adopting the magistrate judge's report and recommendation, the district court held that the plaintiff should not recover for fees and costs incurred during the claim reassessment process because the work done during that process did not further the ERISA litigation. The Eleventh Circuit found that the claim resolution process in which the plaintiff and UNUM engaged was not an administrative proceeding that should be considered part of the judicial action for which fees could be awarded. The circuit court ruled that the nature of the proceeding was analogous to a pre-litigation administrative proceeding. As the circuit court explained, although the claim reassessment process in which the plaintiff and

UNUM engaged was initiated after the plaintiff's ERISA complaint was filed, it would have been available to the plaintiff even if she had never filed a lawsuit. Simply put, the circuit court found that the claim reassessment process "was a redo of the first administrative appeal." The plaintiff chose to be represented by counsel, but counsel was not required. The circuit court declared that the claim reassessment process at issue in this appeal was not significantly different than the pre-litigation administrative procedures required by ERISA. Because attorney's fees and costs were not available for those pre-litigation administrative proceedings, the circuit court concluded that the district court properly had held that attorney's fees and costs were not available to the plaintiff for work done during the claim reassessment process. [Kahane v. UNUM Life Ins. Co. of America, 2009 U.S. App. Lexis 6957 (11th Cir. March 30, 2009).]

Court Upholds Insurer's Decision That 24-Month "Mental Illness" Limitation Applied to Disability Claim Stemming from Cocaine Dependence

The plaintiff in this case was a partner at a large regional law firm based in Phoenix. In February 2004, the plaintiff was admitted to the Betty Ford Center in California for inpatient treatment for cocaine. The plaintiff apparently did not complete the treatment program and was transferred to another inpatient treatment facility—COPAC in Mississippi—for a higher level of care. The

plaintiff completed COPAC's Phase II treatment program and spent 16 days in the Phase III treatment program. COPAC discharged the plaintiff with a recommendation that he go to a halfway house in Phoenix; he also continued out-patient therapy after his discharge from COPAC.

The plaintiff participated in his law firm's long term disability plan from UNUM Life Insurance Company, which provided for monthly benefits if a participant met the definition of total disability ("because of injury or sickness the participant cannot perform each of the material duties of his regular occupation"). The policy also provided that "benefits for disability due to mental illness will not exceed 24 months of monthly benefit payments." The plaintiff submitted a claim to UNUM; in support of the claim, the plaintiff's physician reported that the plaintiff had cocaine dependence.

UNUM investigated the plaintiff's claim, accepted it, and began paying monthly benefits of \$35,000 from August 23, 2004. About two years later, UNUM informed the plaintiff's counsel that the plaintiff would reach the 24-month maximum duration date as of August 22, 2006, and that his benefits would end. UNUM invited the plaintiff to submit evidence showing his disability was not subject to the mental illness limitation.

In his response, the plaintiff's counsel wrote that the plaintiff suffered from both cocaine addiction and depression. Counsel acknowledged that depression was a mental illness, but argued that cocaine addiction had both physical and mental causes and physical and mental symptoms. Three days later, counsel provided a declaration from the plaintiff's physician that stated:

Severe substance abuse occurring over an extended period of time, such as that sustained

by [the plaintiff], may cause neurological and cognitive impairment which can impair a person such as [the plaintiff] from performing high level, high stress work for an extended period of time after that person stops his or her substance abuse.

Although the causes of [the plaintiff's] cocaine addiction include some psychological components, the causes also include physical components, including changes in brain chemistry. Similarly, although the addiction manifests itself through certain psychological symptoms, such as his depression, the addiction also has certain physical symptoms, such as physical craving of cocaine.

UNUM reviewed all the information in the file, including the opinions of the plaintiff's physician and physicians it retained to review plaintiff's medical records, and concluded that the plaintiff's claim based upon cocaine addiction was subject to the mental illness limitation. The plaintiff appealed and, after a final review of the entire record by other physicians it retained, UNUM upheld the determination that the plaintiff's benefits were subject to the mental illness limitation. The plaintiff brought suit, and UNUM moved for summary judgment.

The district court granted UNUM's motion. After reviewing the record, the district court found that UNUM had not abused its discretion in terminating the plaintiff's disability benefits pursuant to the plan's 24-month mental illness limitation. The record before UNUM contained numerous professional opinions, from psychiatrists, nurses, and a neurologist, that the plaintiff's disability resulted from drug addiction, which they found was a mental illness. In fact, the

court pointed out, the American Psychiatric Association's Diagnostic and Statistical manual (DSM IV), which is the standard classification of mental disorders used by mental health professionals in the United States, classified addiction as a mental disorder.

Further, the court continued, although the plaintiff's treating physician opined that prolonged drug addiction like the plaintiff's could lead to cognitive and neurological deficits, he did not state that the plaintiff in fact suffered from such deficits. The court also noted that the plaintiff also did not present UNUM with any physical test results, such as an MRI scan, showing cognitive or neurological damage.

The court concluded that the file before UNUM supported its decision that although the plaintiff's addiction may have resulted in both mental and physical symptoms, the symptoms and the causes of his addiction were primarily mental in nature. Even the plaintiff's treating physician conceded that the plaintiff's addiction was primarily a psychiatric issue. Given that record, the court concluded that UNUM had not abused its discretion in finding that the mental health limitation unambiguously applied to the plaintiff's claim. [Kelly v. Unum Life Ins. Co. of America, 2009 U.S. Dist. Lexis 32830 (D. Ariz. Apr. 14, 2009).]

Plaintiff's Suit for Bad Faith Refusal to Pay Disability Insurance Claim Is Rejected

The plaintiff in this case was covered under a blanket accident disability insurance policy issued by Stonebridge Life Insurance Company to HealthExtras, Inc. The policy paid

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an accident disability benefit under the following circumstances:

If an Injury to an Insured results in any of the following Losses, the Company will pay the Accident Disability Benefit shown in the schedule. The Accident Disability Loss must occur within 365 days of the accident and the Insured must survive for at least 180 days from the date of the Accident Disability Loss. The Company will not pay a benefit until the 180-day period has been satisfied.

The policy also provided enhanced benefits for an insured who suffered a loss while wearing his or her seatbelt and for home alteration and vehicle modification. The accident disability benefit was a \$1 million lump sum payment and the enhanced benefits were \$10,000 for the seatbelt benefit and a \$10,000 home alteration/vehicle modification benefit.

The plaintiff was injured in an automobile accident on January 13, 2007, when he attempted to pass an 18 wheeler, went off the roadway, and struck some trees. The plaintiff's wife contacted Stonebridge on January 24 to report the injury and to request claim forms for the disability benefit. Stonebridge advised her that the policy provided coverage if the loss occurred "within 365 days of the date of the accident and the Insured must survive for at least 180 days from the date of the Accident." Stonebridge also advised the plaintiff's wife that the plaintiff also had separate accident hospital benefits and provided her claim forms for this coverage.

On July 16, 2007, the plaintiff's wife contacted Stonebridge and requested forms for submitting a claim for the disability benefit. Stonebridge immediately began its investigation and kept the plaintiff and his attorney informed throughout the course of its investigation.

However, there was a course of events that slowed Stonebridge's investigation.

The first delay occurred when the Methodist Rehabilitation Center refused to provide the plaintiff's medical records because he was still admitted and undergoing treatment. The record reflected that Stonebridge regularly inquired about his admission status and obtained the records as soon as Methodist Rehabilitation Center would release those records.

Once Stonebridge obtained those records, on October 8, 2007, it determined that an independent medical exam (IME) was appropriate. After the IME was conducted on November 30, 2007, the physician who conducted it became ill and was hospitalized. Stonebridge repeatedly contacted the physician's office in an attempt to secure the IME report and updated the plaintiff and his attorney on its progress in obtaining the IME report, which it finally received on January 28, 2008.

The Stonebridge claims manager recommended payment of the claim the next day. His supervisor reviewed the claim on January 30 and approved the recommendation. It was then routed to Stonebridge's chief financial officer, who approved payment on February 4. That same day, however, the plaintiff's attorney faxed a copy of a lawsuit, originally filed on January 31, to Stonebridge. Stonebridge contacted the plaintiff's attorney to advise him that payment of the claim had been approved and requested he dismiss the suit. The attorney declined and asked Stonebridge to issue the check payable to him and the plaintiff, which was done that day, February 5. The check was negotiated by the plaintiff on February 7. A total of \$1,020,000 was paid, which represented policy limits of \$1,000,000 for total disability, \$10,000 for seat belt benefits, and \$10,000 for home modification benefits.


The plaintiff's lawsuit asserted claims for breach of contract and for bad faith failure to pay an

insurance claim. The substance of the plaintiff's second count was that "the delay in paying the claim [was] patently unreasonable." The plaintiff contended he suffered damages for "lost insurance benefits, emotional distress, attorney's fees, interest and costs." He sought compensatory, extra-contractual, and punitive damages. Stonebridge moved for summary judgment.

The plaintiff argued that the delay in processing the plaintiff's claim from January 24, 2007, until July 16, 2007, was unreasonable. He conceded that what Stonebridge did after the 180-day survival period expired was legitimate and timely. However, he contended that Stonebridge should have commenced its investigation between the January 24 notification date of the plaintiff's injury and the expiration of the 180-day period, and its failure to do so was tantamount to bad faith. Stonebridge responded by asserting that no coverage existed until the expiration of the 180-day survival period and that it was not legally obligated to begin its investigation until that time. It also asserted that, in any event, an investigation undertaken earlier than it did would have been delayed by the refusal of the Methodist Rehabilitation Center to release all of the records of the plaintiff until he had been discharged.

The court granted Stonebridge's motion, explaining that the policy section entitled "COVERAGE" stated there was no "Coverage" unless (1) there was an Injury, (2) the accident disability loss occurred within 365 days of the accident, (3) the 180-day survival period had been satisfied, and (4) there was permanent, complete, and irreversible loss of use of one of the extremities enumerated therein. It was only after the expiration of the 180-day survival period and the furnishing of due proof of disability that Stonebridge could have any liability under the policy. The plaintiff's right to benefits did not arise until he survived 180 days beyond the date of his injury. There was no obligation on the

part of Stonebridge to begin its investigation until the expiration of this time period.

Therefore, the court granted Stonebridge's motion for summary judgment and dismissed the complaint. [Barnes v. Stonebridge Life Ins. Co., 2009 U.S. Dist. Lexis 21623 (S.D. Miss. March 18, 2009).] 

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Assessing and Avoiding Risk of Adverse Tax Consequences for Partnerships Under the “Golden Parachute” Payment Rules

Internal Revenue Code Section 280G denies an income tax deduction for, and Code Section 4999 imposes a nondeductible 20 percent excise tax on, certain compensatory payments (excess parachute payments) to “disqualified individuals” that are contingent upon a change in the ownership or control, or ownership of a substantial portion of the assets (a change in control), of a *corporation*. Disqualified individuals generally are defined as employees or independent contractors who are shareholders, officers, or highly-compensated individuals of a *corporation*.

SECTION 280G AND PARTNERSHIPS

If a transactional employee benefits lawyer were asked whether Code Section 280G applies to employees of a *partnership*, he or she likely will respond in the negative. (Unless noted otherwise, the term “partnership” means an entity treated as a partnership under the Code.) Numerous articles and treatises on the subject consistently conclude that a change in control relating to a partnership will not trigger Code Section 280G and that partnerships need not be concerned with Code Section 280G. However, as discussed herein, that blanket assertion may not be correct due to the partnership anti-abuse Treasury Regulations.

Under Code Section 280G, the term “corporation” generally includes associations, joint-stock corporations, insurance companies, and publicly traded partnerships. However, the definition of “corporation” does not include nonpublicly traded partnerships. Code Section 280G generally provides that all members of the same affiliated group (as defined in Code Section 1504) will be treated as one corporation and any person who is an officer of any member of the affiliated group will be treated as an officer of one corporation. However, because partnerships cannot be members of affiliated groups under Code Section 1504, payments to employees of a partnership would not appear to be subject to Code Section 280G.

However, consider the following fact pattern. Corporation A owns 90 percent of Partnership P (a joint venture) and unrelated Corporation B owns 10 percent of Partnership P. Corporation A’s 90 percent share of Partnership P’s assets represents more than one-third of the total fair market value of Corporation A’s assets. Partnership P is sold to an unrelated buyer, causing each of its partners to be treated as having sold its proportionate share of Partnership P’s assets. Accordingly, the sale of the Partnership P assets constitutes a change in control of Corporation A under Code Section 280G. Note that under Code Section 280G, a change in the ownership of a substantial portion of a corporation’s assets occurs when a person or a group of persons acquires assets from the corporation that have a total gross fair market value equal to or more than one-third of the total gross fair market value of all of the assets of the corporation immediately prior to the acquisition. CEO has been the chief executive officer of Partnership P for the entire tenure of the entity. Partnership P and CEO are parties to an employment agreement that entitles CEO to receive a bonus (the Sale Bonus) equal to four times CEO’s annual base salary plus bonus in the event of a sale of substantially all of the assets of Partnership P. CEO is an officer of a partnership, not a corporation, so isn’t CEO immunized against Code Section 280G? Maybe not.

PARTNERSHIP ANTI-ABUSE REGULATION

Treasury Regulation § 1.701-2(e), a partnership anti-abuse regulation, gives the Internal Revenue Service (IRS) authority to “treat a partnership as an aggregate of its partners in whole or in part as appropriate to carry out the purpose of any provision of the Internal Revenue Code or the regulations promulgated thereunder.” This principle is illustrated by Example 1 to § 1.701-2(e), which provides that a corporate partner in a partnership should be treated as issuing its share of debt instruments

issued by a partnership, reasoning that “[t]he purpose of section 163(e)(5) is to limit corporate-level interest deductions on certain obligations. The treatment of [the issuing partnership] as an entity *could result* in a partnership with corporate partners issuing those obligations and thereby circumventing the purpose of section 163(e)(5)” (emphasis added). A significant aspect of this example is that it purports to give the IRS authority to disregard a partnership as an entity, irrespective of whether the partnership is created with a tax avoidance purpose or enters into an abusive transaction, as appropriate to carry out the purpose of any provision of the Code or Treasury Regulations.

On the strength of Treasury Regulation § 1.701-2(e), could the IRS successfully assert that Partnership P should be disregarded and treated as an aggregate of Corporation A and Corporation B, with each partner treated as co-employing CEO and as having paid its proportionate share of the Sale Bonus? If so, CEO would be treated as an officer of Corporation A and Corporation B. That would make CEO a “disqualified individual” with respect to Corporation A, in particular, and subject the Sale Bonus to Code Section 280G and the Code Section 4999 excise tax.

A review of IRS guidance has revealed no application of the partnership anti-abuse regulations in the Code Section 280G or 4999 context.

Treasury Regulation § 1.701-2(e) has been widely criticized and the abuse-of-entity rule itself has rarely been invoked or explicated. Accordingly, it is not known (i) whether the IRS would invoke the regulations in the Code Section 280G or 4999 context and (ii) what characteristics of the partnership structure and transaction the IRS would consider important in determining whether disregarding the partnership was “appropriate” to carry out the golden parachute provisions; e.g., would it matter in the fact pattern above if Corporation A was a 50 percent or 99 percent owner of Partnership P, rather than a 90 percent owner? In any event, the breadth of the partnership anti-abuse regulations appears to create some risk that Code Section 280G or 4999 could apply to a change in control of a joint venture or other partnership—or at least that the IRS could assert such a position.

SHAREHOLDER APPROVAL EXCEPTION

Where such a risk is present, it may be possible to eliminate it by using the shareholder approval exception under Code Section 280G. Under the shareholder approval exception, the adverse tax consequences under the golden parachute payment rules generally can be avoided if:

- No shares of the target are readily tradable;
- The parachute payments are approved by a vote of the

holders of more than 75 percent of the voting power of all outstanding shares of stock of the target, excluding shares held by disqualified individuals and related persons;

- The target stockholder vote to approve the payments is separate from the vote to approve the change in control;
- There is adequate disclosure to shareholders of all material facts concerning all payments that would be parachute payments but for this exception; and
- The vote determines the right of the disqualified individuals to receive or retain the parachute payments (i.e., if a disqualified individual is contractually entitled to receive a payment, the shareholder approval exception would apply to such payment only if the individual agrees to give up his right to receive (or agrees to return) the payment in the event the more-than-75-percent-shareholder-vote requirement is not met).

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Managing Pharmacy Benefits in Today's Economy: Strategies to Help Stretch Pharmacy Benefit Dollars

HEIDI C. LEW

To say these times are extraordinary may indeed be an understatement. Perhaps once in a hundred years do we see an economic crisis such as the one now faced by Americans in all sectors of the economy.

Finding ways to manage costs has become a mantra and a mission for employers nationwide. As part of that effort, employers are looking to cut costs wherever possible—including the pharmacy benefit, if necessary. While such efforts may be necessary, they must be undertaken in a strategic and well thought-out manner. Optimal cost-cutting measures should maintain the following key objectives:

- Ensure quality of care;
- Minimize risk to employees and their dependents;
- Maintain employee satisfaction; and
- Promote positive health outcomes.

This quest will be particularly challenging within the pharmacy benefit sector. Programs that reduce the availability or inhibit appropriate utilization of medications, in an attempt to cut pharmacy benefit costs, could backfire on employers. The increased risk of illness, disease progression, and medical co-morbidities could increase visits to the hospital or emergency room and to physician offices, as well as increase the incidence of absenteeism and presenteeism at the workplace.

The temptation in today's economy may be to drastically reduce pharmacy benefits or increase employee cost sharing. However, achieving optimal cost savings begins with a pharmacy benefit built on programs designed to achieve the best possible clinical outcomes. Reinforcing and improving existing cost saving measures, combined with implementation of innovative programs to help engage physicians and employees in health care decisions are proven strategies to reduce overall health care expenses while improving health outcomes.

GENERIC MEDICATIONS CONTINUE TO HELP CONTROL COSTS

When discussing cost management for pharmacy benefits, one of the key strategies has been and will remain generic formulations of branded medications. Industry sources estimate that more than \$20 billion in popular and expensive drugs such as Avandia® (diabetes); Flomax® (enlarged prostate); Lipitor® (high cholesterol); Valtrex® (herpes); and Prevacid® (heartburn) are expected to become generically available over the next three years.¹

The good news is that employers and employees today understand the value of generics. Nearly two billion prescriptions are filled with generic medicines every year. In 2008, generic medicines were used to fill 65 percent of all prescriptions dispensed.² Despite this fact, generics only account for 16 percent of the annual drug spend.³

The cost saving potential of generics continues to be significant and therefore well worth maximizing. The average cost of a typical generic prescription is 30 to 80 percent less than its branded counterpart, saving consumers from \$8 to \$10 billion a year at retail pharmacies.⁴

While many employers have already implemented strong generic programs and achieved high utilization rates, there are a number of strategies to be explored and implemented to create further cost savings.

Recognizing the complexity of the marketplace, some pharmacy benefit managers (PBMs) offer multi-tiered generic formularies or incorporate other strategies to lower overall medication costs. The key to a successful generic medication program is to emphasize and promote the total health management of the patient.

Even this approach may prove complex in some instances. Because no two individuals are the same, what may be therapeutically appropriate for one individual with a certain disease, may not be optimal for another with the same condition. For example, Angiotensin-Converting Enzyme, or ACE inhibitors are a group of medications that

are used primarily in the treatment of hypertension (high blood pressure) and congestive heart failure, or to slow progression of kidney disease among patients with diabetes. There are multiple generic options available within this therapeutic category, making it one of the more commonly prescribed medications. Similarly, Angiotensin II Receptor Antagonists, also known as Angiotensin Receptor Blockers (ARBs), are a group of medications that are also used to treat similar indications as for ACE inhibitors.

However, ARBs have no generic equivalents and thus the cost difference between ACE and ARBs can be significant. Therefore, the question for physicians—as well as for plan sponsors working with PBMs to manage costs—is when to use which medication. In most cases, the ACE inhibitor will provide the desired therapeutic outcomes. However, some patients who are unable to tolerate ACE inhibitor therapy and thus would not be able to gain medical benefit from such therapy. These patients may benefit from ARB therapy in place of an ACE inhibitor. PBMs can utilize step therapy programs to effectively manage the appropriate use of these medications for its plan members.

Under a step therapy program, unless clinically indicated, patients first have access to lower cost medications with proven efficacy. If desired therapeutic outcomes are not achieved, then they will be approved to receive a higher cost drug alternative. Step therapy programs work best when they also include a clinically focused prior authorization component that will allow physicians to immediately override a generic or even preferred branded medication in exchange for the medication that the prescriber believes is most appropriate for his or her patient.

STRATEGY KEY TO EFFECTIVE GENERIC PROGRAMS

The key to effective generic programs in today's marketplace is to

have a well thought-out strategy that ensures the right patient is on the right generic for the right period of time. For example, consider a program that provides pre-notification to members when a branded drug is about to lose its patent and a generic is becoming available. As soon as the benefit changes (that is, when the PBM has ensured the generic provides optimal cost savings), another letter goes out to the member and their physician to let them know that the generic is available at a reduced copay. Two to four months following the initial letter, a retrospective claims analysis is conducted to determine if members have changed to the generic. If not, another round of mailings is sent to members who have not responded and their physicians.

The program includes a telephone outreach component where an automated call is made to the member to let them know that the generic is available and to recommend the members to discuss the therapeutic benefits, along with any questions, with his or her physician(s).

Programs such as this have proven highly successful. Some PBMs are able to achieve generic substitution rates of more than 90 percent within just one month of a drug becoming available as a generic. This prompt transition can save employers millions of dollars, especially when blockbuster branded drugs become available as a generic.

MAIL SERVICE

Mail service pharmacy is yet another core strategy for controlling pharmacy benefit costs. Over the past decade, mail service pharmacy has rapidly become a popular method for delivering prescription medications, particularly for older populations or those with chronic illnesses.

However, with the advent of low-cost generics and retail pharmacies offering 90-day supplies, employers and employees have renewed interest in determining which option

ultimately provides the best cost savings. When considering a mail service pharmacy, it is important not only to consider cost—but other program components as well. In tight economic times, it is not just about reducing costs; the challenge is also to ensure overall value to and satisfaction of the employer and employee.

The best mail service pharmacies today do more than just deliver medications. They also offer clinical programs that provide important education, communication, and drug safety features. Members can call from the privacy of their home to speak to a pharmacist about their prescriptions anytime, day or night. The leading mail service facilities also use the latest technological innovations combined with multiple redundant safety checks to ensure prompt and safe delivery. Filling accuracy rate at top mail service PBMs is in excess of 99.99 percent which is very difficult to match by other prescription delivery systems, including retail pharmacies.

Mail service provides the benefit of integration of prescription information for all of the member's prescriptions written by all prescribers treating the member and filled at all pharmacies they patronize. This capability is especially important for employees with multiple prescribing providers. It is estimated that older employees, on average, take three to five separate prescriptions, greatly increasing the chance for potentially harmful interactions. Mail service safety programs can check for drug-to-drug interaction and identify if a patient may be taking a medication that may be dangerous or lead to an adverse reaction when combined with another prescription drug. Additionally, PBMs will also often use mail service to provide important reminders (e.g., missed prescriptions, appropriate compliance guidelines) and for educating employees about the importance of diet, exercise, and lifestyle changes to prevent and/or manage certain diseases.

■ Pharmacy Benefits

Mail service is not for every employee. It works best for chronic medications such as those for hypertension, heart disease, or diabetes management. However, when used as part of a comprehensive pharmacy program, it can provide key benefits to employers and employees. Employers can achieve savings of up to 10 percent when employees use mail service, representing millions of dollars for large- to mid-size employers. Employees can save as well, particularly those on branded medications or with tiered generic copayments. In addition, workers can secure the added benefit of convenience and with leading mail service pharmacies, the ability to talk 24/7 directly and privately to a pharmacist by phone or e-mail.

While mail service and generics represent two important areas to address in cost saving programs, there are other options to consider as well. Employers seeking to maintain quality and control costs should also consider the following steps.

STEPS TO TAKE FOR COST SAVINGS AND QUALITY CARE

Revisit Your Formulary

One of the best ways to control costs is with a tight, yet clinically driven formulary. The focus of the formulary must be on the inclusion of medications that are clinically proven to minimize total health care costs while striving for the best possible health outcomes. This allows plan sponsors to keep premiums down, lower their costs, and improve the quality of health care for employees.

Institute Utilization Management

Over the past few decades, utilization management (UM) has gone in and out of favor. Many health plans favored a richer benefit and dropped many proven UM tactics. Now is the time to revisit the strategy which includes step therapy and prior

authorization, as well as prospective and retrospective review.

Implement Strong Patient Safety Medication Programs

PBMs with the ability to provide a range of programs designed solely to ensure the safe and effective utilization of prescription medications can help save employers money and improve employees' health. Medication-related errors and adverse events are the leading cause of hospitalizations. Polypharmacy programs can help to identify potentially harmful duplicate medications or ones that may no longer be needed or potentially dangerous for that employee. Adverse Drug Reaction programs will help to prevent costly hospitalizations, inappropriate medical resource utilization, and even death. Many PBMs offer a wide range of safety programs and will work with employers to implement those that are of most value to an employee population.

Engage Physicians in Cost Control Efforts

Numerous studies over the past few years have shown that one of the best ways to promote healthy behaviors is to encourage strong physician and patient relationships whereby the physician becomes the agent to educate and motivate change. However, physicians today are busy and can benefit from information to help them learn about new medication guidelines and studies as well as assistance to efficiently identify patients who are at risk or who could benefit from clinical intervention. Most physicians are more than willing to become partners in efforts to control costs—if it is clinically the best choice for their patient. PBMs with clinical programs that work in concert with physicians will be able to develop partnerships that benefit employers and employees.

Encourage Compliance

It is estimated that about one-half of consumers are noncompliant

with taking their prescriptions and, therefore, are getting a submaximal effect from their medications. This situation represents wasted benefit dollars in terms of actual costs and increases the potential for negative health outcomes. Education programs (especially used in conjunction with mail service), coordination and collaboration with physicians and other available company communication programs (e.g., newsletters, Web sites) should be used to promote and encourage patient compliance to prescribed medication therapies.

Know Your Benefit

Communication and education can also play an important role in familiarizing employees with the specifics of their benefit design. To help control costs and make employees a partner in not only their health care, but also efforts to control costs, employees must know and understand their benefit design, including copays, generic options, preferred medications, and other features.

Conduct Prescription Reviews with Physicians and Pharmacists

Periodic prescription medication reviews help to ensure patients are only on those medications that provide desired medical outcomes. Over the years, and particularly if they are seeing more than one physician, employees may be taking medications which they no longer need, potentially placing them at risk for polypharmacy. Or, they may be taking drugs for which there are more effective alternatives. Ensuring that physicians and/or pharmacists review *all* medications can help to ensure safe, appropriate and effective prescription utilization. Employees, physicians, and pharmacists alike should be encouraged to periodically review all medications a patient is taking—including over-the-counter (OTC) nonprescription medications.

Communicate

A central component of virtually every proven pharmacy benefit strategy is communication. Whether it's an employee talking to his or her physician about generic options; a PBM talking to physicians about patients that might benefit from specific medication therapies; or pharmacists suggesting a lower cost but therapeutically equivalent medication, communication about pharmacy benefits will be key in managing pharmacy benefit costs in the coming months and years. All stakeholders in the system need to feel empowered to ask questions, share concerns and provide alternatives in an effort to improve quality and control costs.

WORTH THE EFFORT

Today's volatile economy will continue to place a burden on employers to find ways to reduce spending. While health care reform is coming, its exact timing, form, scope, and effect are largely unknown and may come incrementally. Employers struggling to survive need programs that can provide real value and cost savings today.

Strengthening existing programs—particularly those promoting generic medications and utilization of sophisticated mail service pharmacies—and emphasizing education, communication, and collaboration with all stakeholders are steps that can be taken now and that will provide real results today and tomorrow. 🌐

NOTES

1. See <http://drugtopics.modernmedicine.com/drugtopics/data/articlestandard//drugtopics/172008/511856/article.pdf>.
2. See <http://www.gphaonline.org/about-gpha/about-generics/facts>.
3. See <http://www.modernmedicine.com/modernmedicine/Top+news/Insurance-companies-urging-switch-to-generics/ArticleStandard/Article/detail/572094?searchString=generics%20spending>.
4. *Ibid.*

Heidi C. Lew, Pharm. D., serves as vice president of clinical programs for Prescription Solutions, a UnitedHealth Group pharmacy benefit management company. In this capacity, she oversees all clinical program development, including specialty pharmacy programs, and is responsible for supporting the drug formulary development process with the Pharmacy and Therapeutics Committee.

New COBRA Subsidy Requirements

Earlier this year, President Barack Obama signed into law sweeping economic stimulus legislation known as the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA includes a number of provisions designed to assist unemployed workers and their families, including federally subsidized COBRA¹ premiums.

COBRA GENERALLY

Under COBRA, employees and their spouses and dependent children who participate in certain group health plans and who lose coverage due to certain qualifying events (such as termination of employment, death, or divorce) must be permitted to elect to continue group health plan coverage at favorable group rates. Individuals who lose group health plan coverage are known as “qualified beneficiaries.” Under COBRA, continued coverage must generally be made available for up to 18 months.² Group health plans may charge covered employees and their spouses and dependent children the full cost of the COBRA coverage, plus a two percent administrative fee.

NEW COBRA SUBSIDY REQUIREMENTS

Under ARRA, the federal government will subsidize up to 65 percent of the COBRA premiums for certain “assistance eligible individuals” or “AEIs” for up to nine months.

ARRA’s COBRA subsidy provisions impose new requirements on companies sponsoring group health plans and their insurers and administrators, including the obligations to:

- Temporarily subsidize COBRA premiums for AEIs;
- Offer “second chance” COBRA elections to certain AEIs;
- Notify COBRA qualified beneficiaries of their new COBRA rights;
- Maintain records related to COBRA subsidies and file reports with the government; and
- Update HIPAA³ coverage crediting procedures.

The new COBRA requirements became effective immediately upon enactment. The

new requirements apply to group health plans covered under federal COBRA law, under the Federal Employees Health Benefits Program (FEHBP) and, in certain respects, under any similar state laws (often referred to as “mini-COBRA” laws).

The new COBRA subsidy requirements are highlighted in Exhibit A: “COBRA Subsidy Basics” and are summarized in more detail in this article.

COBRA SUBSIDY GUIDANCE

The new COBRA subsidy requirements are generally set forth in Section 3001 of ARRA. The Internal Revenue Service (IRS) has issued comprehensive guidance on the new COBRA subsidy requirements in IRS Notice 2009-27 and has published additional guidance on its Web site.⁴ The Department of Labor (DOL) has issued model COBRA forms and instructions,⁵ and other guidance is available on its Web site.⁶ The DOL, in conjunction with the Treasury Department and IRS, has also sponsored several Web casts describing the new COBRA subsidy requirements.⁷ Additional guidance is also expected to be issued.

Subsidy Eligibility

Assistance Eligible Individuals

The federal COBRA subsidy is available to all assistance eligible individuals. AEIs include employees and their covered spouses and dependent children who:

- Are COBRA qualified beneficiaries as a result of an involuntary termination that occurs between September 1, 2008 and December 31, 2009;
- Lose group health plan coverage resulting in eligibility for COBRA coverage between September 1, 2008 and December 31, 2009; and
- Elect COBRA coverage.

IRS Notice 2009-27 makes clear that *both* the involuntary termination *and* the loss of group health plan coverage resulting in eligibility for COBRA coverage must occur during the period from September 1, 2008 through December 31, 2009. This means that:

EXHIBIT A: COBRA SUBSIDY BASICS

Assistance Eligible Individuals (AEIs)	<p>Covered employees and their spouses or dependent children who:</p> <ul style="list-style-type: none"> • Are COBRA qualified beneficiaries as a result of an involuntary termination that occurs between September 1, 2008 and December 31, 2009; • Lose group health plan coverage resulting in COBRA eligibility between September 1, 2008 and December 31, 2009; and • Elect COBRA coverage.
Subsidy Amount	<ul style="list-style-type: none"> • AEIs are only required to pay up to 35 percent of the COBRA premium during the subsidy period. • The federal government will subsidize 65 percent of the COBRA premium not paid by or on behalf of the AEI. • No subsidy is provided if the company pays the full cost of the AEI's COBRA premium. • If the company pays part of the cost of the AEI's COBRA premium, the subsidy is reduced proportionately.
Subsidy Reimbursement	<p>Companies must advance the cost of the subsidy and seek reimbursement in the form of a payroll tax credit on IRS Form 941.</p>
Subsidy Recapture	<ul style="list-style-type: none"> • The subsidy is recaptured through a tax increase for individuals who earn more than \$145,000 (single filers) or \$290,000 (joint filers) in the year in which the subsidy is received. • The recapture tax is phased-in for incomes starting at \$125,000 (single filers) and \$250,000 (joint filers).
Subsidy Waivers	<p>AEIs subject to the recapture tax may permanently elect to waive their rights to the subsidy.</p>
Grace Period	<p>For the first two COBRA premium periods beginning after February 17, 2009 (March and April 2009 for most plans), companies may require AEIs to pay the full COBRA premium as long as the AEIs are reimbursed or receive credit toward future COBRA premium payments.</p>
Subsidy Begins	<p>With the first COBRA premium period after February 17, 2009 (March 1, 2009 for most plans).</p>
Subsidy Ends	<p>On the earlier of:</p> <ul style="list-style-type: none"> • Nine months from the date it begins; • The end of the maximum COBRA period (generally 18 months)—for AEIs who elect “second chance” COBRA coverage, the maximum COBRA period runs from the date of the original qualifying event; • The date the AEI fails to pay the required portion of his or her COBRA premium; or • The first date the AEI becomes eligible for coverage under another group health plan or Medicare.
Penalty for Failure to Provide Notice of Eligibility for Other Coverage	<ul style="list-style-type: none"> • An AEI who fails to provide notice of eligibility under another group health plan or Medicare and improperly receives the premium subsidy may be subject to a tax penalty of 110 percent of the subsidy amount.
Maximum Subsidy Period	<p>Nine months</p>
Second Chance Elections	<ul style="list-style-type: none"> • AEIs who lost coverage between September 1, 2008 and February 17, 2009, and who either (a) declined or (b) elected and then terminated COBRA coverage must be given a “second chance” to elect COBRA at the new subsidized rates. • Notice of the right to make a second chance election must have been provided no later than April 18, 2009. • AEIs have 60 days from the date of such notice to elect second chance coverage. • If elected, second chance coverage is retroactive to the first COBRA period beginning on or after February 17, 2009 (March 1, 2009, for most plans).
Lower Cost Enrollment Options	<p>Companies and insurers may permit AEIs to change their COBRA elections to lower cost enrollment options; this provision is optional.</p>
COBRA Notices	<p>Companies and insurers must notify COBRA qualified beneficiaries of the new COBRA subsidy requirements (see COBRA Notices Chart).</p>

continued on next page

EXHIBIT A. CONTINUED

COBRA Reporting	<p>Companies and insurers will be required to maintain and possibly file with the Treasury Department documentation supporting the COBRA subsidy, including:</p> <ul style="list-style-type: none"> • The dates and amounts of premium payment and subsidy reimbursement for each AEI; • An attestation of involuntary termination of employment for each AEI who receives a subsidy; • A taxpayer identification number for each AEI; and • Whether the subsidy is for individual or family coverage.
Expedited Review of Denials	<ul style="list-style-type: none"> • Individuals who apply for and are denied the COBRA subsidy may appeal to the DOL (or other appropriate government agency). • The DOL (or other appropriate government agency) will review and decide the appeal within 15 business days. • Companies and insurers will be given notice of and the opportunity to respond to the appeal within the 15-day period.

- If the employee is involuntarily terminated before September 1, 2008, but loses coverage during the period from September 1, 2008 through December 31, 2009, he or she and his or her covered spouse and dependent children are not eligible for the subsidy.
- Similarly, if the employee is involuntarily terminated during the period from September 1, 2008 through December 31, 2009, but loses coverage after December 31, 2009, he or she and his or her covered spouse and dependent children are not eligible for the subsidy.
 - For example, if an employer provides continued health benefits during a severance period that ends after December 31, 2009, and chooses to have COBRA start at the end of the severance period (rather than choosing to have COBRA coverage run concurrently with the severance period), the subsidy requirements do not apply to the employee and his or her covered spouse and dependent children.

Higher Income AEIs

The COBRA subsidy must be made available to all AEIs. However, higher income AEIs are subject to a recapture tax that effectively reduces or eliminates the

subsidy. The subsidy is recaptured through an increase in the higher income individual's income tax liability for the year. The subsidy is recaptured completely for AEIs who earn more than \$145,000 (single filers) or \$290,000 (joint filers) in the year in which the subsidy is received. The subsidy is phased-out through the recapture tax for AEIs with income starting in excess of \$125,000 (single filers) or \$250,000 (joint filers) in the year in which the subsidy is received.

To avoid the recapture tax, higher income AEIs may elect to permanently waive their rights to the subsidy. The waiver must be in writing and should be provided to the person providing the COBRA premium reimbursement. Once made, the subsidy waiver is irrevocable and cannot be reversed even if the AEI later earns less than the income limits.

Involuntary Terminations

To be eligible for the COBRA subsidy, the COBRA qualified beneficiary must lose group health plan coverage as a result of an "involuntary termination" that occurs between September 1, 2008 and December 31, 2009.

IRS Notice 2009-27 provides guidance on what is considered an involuntary termination for COBRA subsidy purposes. IRS Notice 2009-27 provides that an

involuntary termination "means a severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services."

Examples of what does and does not constitute an involuntary termination for purposes of the COBRA subsidy are set out in Exhibit B: "COBRA Subsidy Involuntary Termination Checklist."

IRS Notice 2009-27 makes clear that an involuntary termination is an involuntary termination of *employment*, not an involuntary termination of *health coverage*. This means that the COBRA subsidy is not available if the loss of coverage is due to other COBRA qualifying events such as a divorce or loss of dependent child status.

Subsidy Amount

The federal government will subsidize up to 65 percent of the COBRA premium paid by or on behalf of the AEI. AEIs are only required to pay up to 35 percent of the COBRA premium during the COBRA subsidy period.

IRS Notice 2009-27 provides guidance on how to calculate the amount of the COBRA subsidy.

EXHIBIT B: COBRA SUBSIDY INVOLUNTARY TERMINATIONS CHECKLIST

Includes Termination of Employment Due To	Does <i>Not</i> Include Termination of Employment Due To
<input checked="" type="checkbox"/> Failure to renew a contract, if the employee is willing to execute a contract on similar terms and continue to work	<input type="checkbox"/> Death of the employee
<input checked="" type="checkbox"/> “Good reason” due to employer action that causes a material negative change in the employment relationship	<input type="checkbox"/> Reduction in hours other than to zero (except as noted)
<input checked="" type="checkbox"/> Reduction to zero hours, such as a layoff, furlough, or other suspension of employment resulting in loss of health coverage	<input type="checkbox"/> Retirement (except as noted)
<input checked="" type="checkbox"/> Reduction in hours other than to zero if the employee quits due to such reduction and the reduction is a material negative change in the employment relationship	<input type="checkbox"/> Employee or employee-representative initiated work stoppage
<input checked="" type="checkbox"/> Retirement, if the employer would have terminated the employee’s employment and the employee knew of the pending termination	
<input checked="" type="checkbox"/> Cause (note that if the employee is terminated for “gross misconduct” the employee and his or her spouse and dependent children are not eligible for COBRA)	
<input checked="" type="checkbox"/> Illness or disability (a mere <i>absence</i> from work due to illness or disability is not an involuntary termination)	
<input checked="" type="checkbox"/> Resignation due to a material change in the employee’s geographic work location	
<input checked="" type="checkbox"/> Employer-initiated lock-out	
<input checked="" type="checkbox"/> Employer-initiated “buy-out” where the employer indicates that after the buy-out offer period, a certain number of employees may be terminated	
<input checked="" type="checkbox"/> Call to active military duty (informally noted in DOL’s April 6, 2009 Second COBRA Compliance Assistance Web cast)	

- For purposes of the subsidy, the COBRA premium is the cost that would be charged to the AEI for COBRA coverage if the individual were not an AEI. If a company charges an individual for the full cost of COBRA plus a two percent administrative fee, the COBRA subsidy will be based on such cost plus the two percent fee.
- The COBRA subsidy applies only to the amount paid by or on behalf of the AEI. For example, assume the monthly COBRA premium plus two percent administrative fee is \$1,000.

- If the company requires the AEI to pay the full cost of the \$1,000 premium, the AEI is eligible for a subsidy of \$350 (35 percent of \$1,000) and the employer is eligible for a tax credit of \$650 (65 percent of \$1,000).
- If the company only requires the AEI to pay \$500 of the \$1,000, the AEI is eligible for a subsidy of \$175 (35 percent of \$500) and the company will be eligible for a tax credit of \$325 (65 percent of \$500).
- If a plan that previously charged less than the maximum premium

allowed by COBRA increases the premium to the maximum allowed by COBRA, the subsidy applies to the increased premium.

IRS Notice 2009-27 also clarifies how the COBRA subsidy requirements apply when coverage is provided to both AEIs and individuals who are not AEIs (such as domestic partners). If there is no additional cost to providing COBRA coverage to an individual who is not an AEI, the subsidy applies to the entire COBRA premium. If there is an additional cost to providing

COBRA coverage to the individual who is not an AEI, the COBRA subsidy applies only to that portion of the premium required to cover the AEIs.

COBRA SUBSIDY REIMBURSEMENT

Group health plan sponsors and insurers must advance the cost of the COBRA subsidy and file a claim for reimbursement from the federal government through a payroll tax credit, generally on IRS Form 941, *Employer's Quarterly Tax Return*. The 2009 Form 941 has been updated to reflect the COBRA subsidy requirement. The credit is claimed on line 12a and the number of individuals receiving COBRA subsidy assistance is reported on line 12b. The company sponsoring the group health plan is generally required to advance the COBRA premium and claim the payroll tax credit. However, in the case of an insured plan subject to state law or multiemployer plan, the insurer or multiemployer plan is required to advance the COBRA premium and claim the payroll tax credit.

COVERAGE ELIGIBLE FOR COBRA SUBSIDY

The COBRA subsidy applies to most group health plans. IRS Notice 2009-27 provides that the COBRA subsidy applies to vision-only and dental-only plans, but does not apply to flexible spending arrangements (FSAs) offered under cafeteria plans. The subsidy is also available for health reimbursement arrangements (HRAs). The subsidy also applies to retiree health plans that provide the same coverage to similarly situated active employees (even if a higher premium is charged to retirees).

COBRA SUBSIDY PERIOD

The subsidy coverage period begins on the first day of the first COBRA premium period beginning after February 17, 2009 (March 1st for most plans).

The COBRA subsidy period ends on the earliest of (a) the first date the AEI is eligible for coverage under another group health plan or Medicare coverage, (b) the date that is nine months after the first day of the first month in which the COBRA subsidy applies to the AEI, and (c) the date the AEI is no longer eligible for COBRA coverage. Coverage may end sooner if the AEI fails to pay the COBRA premium on time.

Individuals who become eligible for coverage under another group health plan or Medicare are obligated to notify the current group health plan in writing of such eligibility. An individual who fails to provide this required notice and improperly receives the COBRA subsidy will be subject to a tax penalty of 110 percent of the amount of subsidies improperly received (unless the failure to notify is due to reasonable cause).

The maximum COBRA subsidy period is nine months. IRS Notice 2009-27 makes clear that:

- If an AEI is eligible for other group health plan coverage but chooses not to enroll in such other group health plan coverage, the subsidy does not apply;
- The COBRA subsidy is available after December 31, 2009, for individuals who qualify as AEIs on or before December 31, 2009. For example, an employee who is involuntarily terminated and loses group health plan coverage on September 1, 2009, could receive a COBRA subsidy until May 31, 2010; and
- An AEI is eligible for up to nine months of COBRA subsidy for each involuntary termination.

"SECOND CHANCE" ELECTIONS

The new COBRA provisions require companies to offer "second chance" COBRA elections to AEIs who lost coverage due to an involuntary termination during the period from September 1, 2008 through

February 17, 2009. Notice of the second chance election rights was due by April 18, 2009. An AEI has 60 days from the date he or she receives notice of the second chance election to elect second chance COBRA coverage. If elected, second chance COBRA coverage begins with the first period of COBRA continuation beginning on or after February 17, 2009 (March 1, 2009 for most plans).

Under COBRA, plans must give COBRA qualified beneficiaries 45 days to make the first COBRA premium payment. The same 45-day grace period applies to COBRA premiums made under second chance elections.

The right to make a second chance election is generally available only to group health plans that are subject to COBRA or the temporary continuation coverage requirements of FEHBP. It does not apply to plans subject only to state "mini-COBRA" laws, unless the state law provides for such second chance elections.

LOWER COST COVERAGE OPTIONS

Under COBRA, companies are generally required to offer employees only the right to continue the same coverage the employee had in effect immediately before the COBRA qualifying event. ARRA permits companies to offer AEIs the choice to enroll in or change their coverage to lower cost options. If a company does offer lower cost options, AEIs must choose whether to elect such lower cost options within 90 days of receiving notice of the new options. In deciding whether to offer lower cost options to AEIs, companies should weigh the savings achieved by offering the options against the added administrative requirements in offering the options.

COBRA NOTICE REQUIREMENTS

Notice of the new COBRA rights must be provided to COBRA qualified beneficiaries. In March 2009,

the DOL issued four model COBRA notices and instructions for providing such notices. The notices were required to be provided as soon as possible and, in the case of second election notices, *no later than* April 18, 2009. A company is not required to use the model COBRA notices and may instead develop its own COBRA notices or revise the model notices to reflect the specific provisions of the company's group health plan. These notices are on the DOL Web site⁸ and are summarized herein in Exhibit C: "COBRA Notices."

COBRA REPORTING REQUIREMENTS

To claim the credit, the company, insurer or multiemployer plan must maintain supporting documentation including:

- The dates and amounts of each AEI's COBRA premium and subsidy payments;
- Proof of each AEI's eligibility for the subsidy;

- Each AEI's taxpayer identification number; and
- Whether the premium was for individual or family coverage.

HIPAA REQUIREMENTS

Generally, under HIPAA, a plan is not required to take into account creditable coverage prior to a break in coverage of 63 days or more for purposes of determining pre-existing condition exclusions. However, for AEIs making second chance elections under ARRA, the break in coverage between the date of the AEI's initial COBRA qualifying event and the first date of coverage is not considered to be a break in coverage under HIPAA's creditable coverage and pre-existing condition rules.

EXPEDITED REVIEW OF COBRA SUBSIDY DENIALS

Individuals who apply for and are denied the COBRA subsidy may request an expedited review of the denial. The Department of Labor will decide appeals from

participants in group health plans subject to COBRA. The Department of Health and Human Services will decide appeals for federal, state, and local government employees and from group health insurance coverage provided pursuant to applicable state laws. Both Departments are required to issue a determination on appeal within 15 business days from receiving the completed application for review. The DOL has stated informally that plan sponsors will be given notice of and the opportunity to respond to a request for a review within the 15-day period. An online application for review of a subsidy denial is available on the DOL Web site, with accompanying guidance on the appeals process (available in both English and Spanish).

CONCLUSION

ARRA's new COBRA subsidy requirements impose new obligations on companies sponsoring group health plans and their insurers and administrators. These new

EXHIBIT C: COBRA NOTICES		
Notice	Send To	Comments
General Notice (Full Version)	<i>All qualified beneficiaries</i> (not just AEIs) who experience a qualifying event at any time from September 1, 2008 through December 31, 2009, <i>regardless of the qualifying event</i>	This full version includes information on the premium subsidy as well as information required in the COBRA election notice
General Notice (Abbreviated Version)	AEIs who experienced a qualifying event on or after September 1, 2008, and who have elected and still have COBRA coverage	This is a shortened version of the General Notice—it contains the same information as the full version regarding availability of the COBRA premium and new COBRA rights, but does not include COBRA election coverage information
Alternative Notice	Insured group health plan participants who become eligible for continuation of coverage under state law	This notice is for insurance companies who provide group insurance coverage under applicable state law
Extended Election Period Notice	AEIs (or any individual who would be an AEI if a COBRA continuation election were in effect) who: Had a qualifying event at any time from September 1, 2008 through February 16, 2009, <i>and</i> Either did not elect COBRA coverage or who elected COBRA continuation but subsequently discontinued COBRA coverage	This notice provides information on the additional election opportunities under ARRA, as well as premium subsidy information This notice was due by April 18, 2008

EXHIBIT D: COBRA ACTION CHECKLIST

Action	Deadline*
1. Develop company-specific COBRA action plan <ul style="list-style-type: none"> • Work with internal HR, benefits, IT, payroll, tax, accounting and legal departments as well as insurers, third-party administrators and other outside consultants 	As soon as possible
2. Identify current AEIs <ul style="list-style-type: none"> • See “COBRA Subsidy Basics” chart 	As soon as possible
3. Decide whether to offer lower cost enrollment options for AEIs	As soon as possible
4. Decide how to structure COBRA premium payments and subsidy advances and whether to use two month grace period	As soon as possible
5. Prepare COBRA notices and election forms <ul style="list-style-type: none"> • Consider using model COBRA notices and tailoring them specifically to the company’s group health plan requirements 	As soon as possible
6. Prepare subsidy waiver form for employees who wish to waive the subsidy	As soon as possible
7. Notify participants of new COBRA rights including subsidy, second chance enrollments, and any lower cost enrollment options	April 18, 2009, for notices of “second chance” elections; as soon as possible for all other notices
8. Update procedures for crediting coverage for purposes of HIPAA	As soon as possible
9. Develop internal procedures to maintain records and file documents with the Treasury Department	As soon as possible
10. Develop procedures to address any COBRA subsidy appeals submitted by individuals	As soon as possible

* The COBRA subsidy requirements became effective on February 17, 2009. Compliance with the new subsidy obligations is required immediately.

requirements are effective immediately and require coordination among internal human resources, benefits, IT, payroll, accounting and legal departments as well as insurers, third-party administrators, and other outside consultants. A sample COBRA Subsidy Action Plan is included as Exhibit D. Companies should, if they have not already, develop an action plan to comply with the new COBRA subsidy requirements. 🌀

NOTES

1. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
2. COBRA coverage is generally available for up to 29 months in the case of qualifying disabilities and for up to 36 months in the case of death, divorce, and certain other qualifying events.
3. The Health Insurance Portability and Accountability Act of 1996, as amended.
4. See <http://www.irs.gov/newsroom/article/0,,id=204505,00.html>.
5. See <http://www.dol.gov/ebsa/COBRAmodelnotice.html>.
6. See www.dol.gov/cobra.
7. Available at www.dol.gov/cobra.

8. See <http://www.dol.gov/ebsa/COBRAmodelnotice.html>.

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■ News

Mercer Introduces Retirement Planning Support Program

■ To help participants in the 401(k) plans it administers feel more financially secure and responsive to their investment stake, Mercer has introduced the program “Feel better about retirement.” This feature is an online educational program comprised of podcasts, articles, and interactive retirement calculators to fully educate participants about their investments.

Material for “Feel better about retirement” is updated quarterly and presented in a challenging manner to engage the participant. To illustrate, the initial phase of this alert effort is entitled “401(k) mattressitis,” which describes the consequences of withdrawing money from a qualified retirement savings plan and keeping it accessible, but without any chance to grow. To allay the fear of loss, careful attention is devoted to effectively managing investment risk.

“Feel better about retirement” was inspired by conclusions reached in the 2008 Mercer Workplace Survey and general experience in account activity. Although most participants highly value saving for retirement, three developments have challenged such investment:

- For the second consecutive year, respondents listed “just keeping up with my monthly expenses” as their greatest financial concern;
- 43 percent of respondents think they are not qualified to calculate and plan for the amount of money needed for their retirement; and
- In recent months, more participants have shifted funds into conservative plan options, such as capital preservation funds, and more participants are reducing their contribution rates.

“Feel better about retirement” has been introduced with both the optimistic view that participants genuinely care about and want to oversee their investments, and the cautionary view that participants must take personal responsibility for their retirement in this economically turbulent time.

For more information about “Feel better about retirement,” visit www.mercer.com.

Assurant Employee Benefits Offers Shorter Duration Voluntary LTD Plans

■ To further its efforts in creating quality employee benefits products, Assurant Employee

Benefits has established two and five year plan duration options with its voluntary long term disability (LTD) coverage. These arrangements add flexibility to meet both employee and employer needs. The plans feature 30, 90, or 180 day elimination periods as options for selecting the desired level of coverage.

With these varied recovery periods, the employee now has a financial safety net when deciding between returning to work or adapting to the lifestyle changes necessitated by a prolonged disability. The time frames also allow for stability during the period before the employee becomes eligible for Social Security disability benefits.

The shorter duration plans would apply when a regular occupation/any occupation definition of disability is selected, while the other duration periods would relate to traditional “to age 65” voluntary plan.

For more information about Assurant Employee Benefits’ shorter duration voluntary LTD plans, visit www.assurant.com.

Apex Benefits Group Introduces HEALTHeTrac Program

■ This Indianapolis-based employee benefits firm has developed an electronic based initiative that provides employers a cost and time-saving health and benefits solution. Entitled HEALTHeTrac, the program transmits and exchanges information among the benefits plan, the wellness program, and all onsite clinics utilizing it. This tool coordinates efforts at managing threats of disease, can improve overall employee health by promoting awareness, makes more economical use of resources, and enhances data analysis and time tracking.

Through this program, health providers, human resources departments, insurance carriers, and vendors can be kept apprised of health and benefits developments.

For more information about Apex Benefits Group’s HEALTHeTrac program, visit www.apexbg.com.

Benefit Informatics Enhances Its MEDInnovation® Program

■ To help its clients operate their health plans more prudently in regard to cost containment and risk management, Benefit Informatics has upgraded the claims data analysis features of its MEDInnovation program. Under the revised format, Benefit Informatics has reduced the time gaps in information transmission—in some cases from quarterly or monthly to daily

■ Industry Update

inputs—so that health plan managers can now make adjustments to their health plan configurations in response to emerging developments. The application is available to all stakeholders in the health plan, employees, employers, payers, vendors, or consultants.

For more information, visit www.benefitinformatics.com.

CherryRoad Technologies Acquires Oracle PeopleSoft Enterprise

■ To expand its core capabilities in enterprise software and gain a footing in other markets, CherryRoad Technologies has acquired Tower Perrin's Oracle PeopleSoft Enterprise HCM practice. CherryRoad Technologies president and chief operating

officer, Jeremy Gulban, observed that the added personnel is well versed in technological operations with a work approach that readily complements that of his company. A smooth integration of the expanded work force is expected.

For more information, visit www.cherryroad.com. 🌐

■ Transitions

Baylor University

■ To improve its human resources operations, this educational institution has appointed **John J. Whelan** to serve as associate vice president of human resources. Mr. Whelan most recently was with the University of Notre Dame where he served as director of human resources business partners. Earlier in his career, Mr. Whelan had been manager of human resources at a subsidiary of Bristol-Myers-Squibb and at Gillette Co.

ERISA Industry Committee (ERIC)

■ This nonprofit association, supporting employee retirement, health, and compensation plans of America's largest employers, has named **Gretchen Young** vice president of health policy. Ms. Young joins the organization after most recently serving as vice president of government affairs of Aon Consulting, in that firm's Washington, DC, office.

Farrington Company

■ This leader in benefits communication and voluntary benefits administration has named **Christie Haby** as a new member of its regional marketing directors. Ms. Haby will head the company's new Southwestern regional sales office in Boerne, TX. Ms. Haby has been involved in worksite benefits operations for 13 years, most recently as regional sales director for Benefits Associates.

Forrest Sherer

■ At this insurer's recently held annual board meeting, **Jacque Pentell** was appointed vice president of employee benefits and financial services. This follows Ms. Pentell recently being named manager of the employee benefits department. Ms. Pentell was promoted to assistant vice president of employee benefits in 2008. Earlier in her career, Ms. Pentell worked as a large group underwriter for a major health insurance company and as a college instructor in insurance and medical coding classes.

Giant Food

■ This supermarket chain, operating throughout Virginia, Maryland, Delaware, and the District of Columbia, has named **Paula Labian** as executive vice president of human resources. Ms. Labian most recently held a leadership position in human resources operations for

Whole Foods, and she earlier held human resources positions at Blue Cross Blue Shield of Florida, Harris Specialty Chemicals, and Marine Transportation Services.

Gibson Insurance Group

■ In the employee benefits practice of this South Bend, IN, insurer, **Louise F. Gingerich** has joined on as a client representative in charge of providing marketing and services support for new and existing clients.

Department of Health and Human Services

■ In the office of disability, **Henry Claypool** has been named director. Mr. Claypool has 25 years' experience in developing and implementing disability policy in the public sector. He most recently had been policy director at Independence Care System, a managed long term care provider in New York City.

Mercer

■ To strengthen its expanded defined contribution administration operations, this human resources consulting and outsourcing services provider has hired the following five professionals: **William Callaway**, sales leader of Southeast, Great Lakes, and Midwest regions, based in Nashville; **Derrick Capps**, business strategist, based in Charlotte, NC; **Martin Cole**, sales leader of Northeast region, based in Middletown, N.J.; **Shannon Massey**, business strategist, based in Norwood, MA; **Frank Tighe**, sales leader, West, Northwest, and Southwest regions, based in Houston. Except for Ms. Massey, who formerly worked at AllianceBernstein, all the new members have joined on from Wachovia Retirement Services. Also in the company, **Elizabeth Antin** has joined on as relationship manager. Ms. Antin most recently had been vice president of client services at ING America.

Profit Sharing/401k Council of America

■ This national organization has named **Robert A. Benish** vice president of membership and operations. He will oversee all daily activities, including programs, publications, and conferences. For more than two decades, Mr. Benish has held management positions for a number of mutual funds and investment companies. He most recently had been president of the Retirement Education Center, an organization he founded.

■ Industry Update

Northern Power Systems, Inc.

■ To strengthen its commitment toward becoming a player in the wind power industry, this energy source provider has named **William E. Decker** as chief human resources officer. Mr. Decker joins the firm after having served as senior vice president of human resources for National Life Group.

Payflex Holdings, Inc.

■ At this Omaha-headquartered administrator of employee benefit programs, **Robert L. Natt** has been named chief executive officer. Mr. Natt joins the firm after most recently serving as president and chief executive officer of MBI Benefits, a leading provider of debit cards for benefit spending accounts.

Ropes & Gray

■ In the ERISA and compensation practice of this New York law firm, **Andrew Oringer** has joined on to head operations as a tax and benefits partners. Mr. Oringer most recently headed the same practice in the law firm White & Case. He also serves as an adjunct professor at Hofstra University School of Law.

Service Source

■ This San Francisco performance management services provider, supporting the high-tech industry, has named **Jeff Bizzack** president. Mr. Bizzack most recently had been managing director and chief executive officer of Accenture BPO Services LLC, where he oversaw expanded account and human resources outsourcing initiatives.

Strategic Employee Benefits Services

■ Joining this Greensboro, NC-based firm as an associate employee benefits specialist is **Lesley Burnham**, who will focus on marketing and selling products to a variety of carriers. For the past 12 years, Ms. Burnham has been active in the Piedmont Triad business community.

Triangle Benefits Forum

■ At this professional group, focused on promoting excellence in employee benefits management, **Clayton Christian** has been named chief operating officer. His primary role will be on bolstering technology support and maintaining communications channels. Mr. Christian is a CPA with Hughes Pittman & Gupton, a leading North Carolina-based CPA firm. He is in charge of the firm's employee benefits plan audit practice. 🌐

■ Publications, Etc.

Questions & Answers on Life Insurance: The Life Insurance Toolbook, written by Anthony Steuer, published by iUniverse, Inc., 464 pages

This definitive guidebook clarifies the complicated issue of life insurance and presents straightforward explanations about the basics and finer points of this almost universally indispensable financial support tool. Mr. Steuer draws on his 20 years' experience in the insurance industry to relate the most pressing issues. The many informative topics include:

- Differentiating between types of policies;
- Understanding how various insurance arrangements work;
- How to prudently identify and evaluate a policy and company;
- Procedures for hiring a trusted agent;
- Understanding the practice of underwriting; and
- Properly monitoring a policy.

For more information about Questions & Answers on Life Insurance: The Life Insurance Toolbook, visit www.tonysteuer.com.

RIA's Complete Analysis: Tax and Benefits Provisions of the American Recovery and Reinvestment Act, published by Thomson Reuters, \$69.95

The recently enacted American Recovery and Reinvestment Act addresses many tax and benefits questions, including:

- What are the tax implications for business and individuals?;
- Who is eligible for the subsidized COBRA coverage, and what related notification responsibilities are required of health plan administrators?;

- How are group health plans supposed to accommodate those employees and their dependents who are eligible for Medicaid or the Children's Health Insurance Program?;
- What portion of an employee's income can be excluded for qualified fringe benefits?;

The answers to these, and many other, questions are addressed in detail in this comprehensively-researched sourcebook. Also provided are the amended Internal Revenue Code and ERISA sections, applicable Committee Reports, and support features to better illustrate and highlight the accounts.

For more information about RIA's Complete Analysis: Tax and Benefits Provisions of the American Recovery and Reinvestment Act, visit www.thomsonreuters.com.

5500 Preparer's Manual, written by Janice M. Wegesin, published by Aspen Publishers—a division of Wolters Kluwer Law & Business, \$300

This annual guidebook enables filers to successfully handle the required Form 5500 filing for both pension benefits and welfare benefits. Among the issues addressed are:

- ERISA filing acceptance system (EFAST) processes and requirements;
- Benchmarks to consider when evaluating fidelity coverage purchased to comply with ERISA Section. 412;
- SEC Form 11K filing required for plans with publicly traded employer stock;
- How to correct errors discovered after initially filing forms;
- Filing requirements of a terminated plan, and much more.

For more information about the 5500 Preparer's Manual, visit www.aspenpublishers.com.

■ Calendar

August

August 3–6

Workplace Benefits Mania. Paris Hotel & Casino, Las Vegas, NV. Sponsored by Workplace Benefits Association. For more information, contact WBA, (888) 282-1765, (330) 425-8489, www.workplacebenefits.org.

August 4 & 5

MBGH 3rd Annual Pharmacy Benefits Academy. Hyatt Regency O'Hare, Rosemont, IL. Sponsored by the Midwest Business Group on Health. For more information, contact MBGH, (312) 861-1100, fax (312) 372-9091, www.mbgh.org.

August 9–12

ISCEBS 28th Annual Employee Benefits Symposium. Mandalay Bay & Resort Casino, Las Vegas, NV. Sponsored by the International Society of Certified Employee Benefit Specialists. For information, contact the ISCEBS, (262) 786-8771, fax (262) 786-8650, www.iscebs.org.

August 10–12

Fundamentals of Human Management. AMA New York Center, New York, NY. (Conferences also held in September, October, and November at other locations.) Sponsored by the American Management Association. For information, contact the AMA, (877) 566-9441, www.amanet.org.

August 14 & 15

ASPPA® College of Pension Actuaries Conference. Embassy Suites Chicago, Chicago, IL. Sponsored by American Society of Pension Professionals & Actuaries. For information, contact ASPPA, (703) 516-9300, fax (703) 516-9308, www.asppa.org. 