BEST PRACTICES IN
Compensation & Benefits

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Reducing Pay, Hours, Employees? Think Before You Act

Lisa Van Fleet, a partner with the law firm Bryan Cave LLP, enjoys working with employers to help them solve problems related to their deferred compensation and benefit plans.

Typically, the problems are varied, sometimes stemming from changes in the law, and sometimes from changes employers decide to make. Either way, Van Fleet or her colleagues find satisfaction in helping employers solve a variety of problems.

Times have changed for all of us. Since the last quarter of 2008 and continuing until we spoke with Van Fleet in the second quarter of 2009, the requests she's receiving for help have developed a decided pattern. What's the single theme of many of the calls? Cutting costs associated with compensation and benefits.

"Every day, Van Fleet explains, "we get calls asking things like, *How can we eliminate our match? What if we change our benefits program mid-year? How do we manage a reduction-in-force? How do we put together severance pay packages?*

"Those things have been the daily meat of our work for the last 6 months—that, and trying to jump through the new hoops that the Obama administration is creating for employee benefits," she adds.

"The funny thing is," Van Fleet says, "up until midnight on December 31, 2008, we were working with people to bring their deferred compensation plans into compliance with IRC Section 409A, the new executive compensation rules.

"Then, almost at the stroke of midnight, we were trying to help them take compensation away, or at least convert it, from those same people. Ironically, 409A, which was designed to prevent executive abuses, actually impedes your ability to take compensation back."

Cutting Executive Compensation

Van Fleet sees two broad areas of concern for the companies she consults. "One is mid-year program changes in executive compensation. We have employers who want to make mid-year changes in their executive compensation packages," Van Fleet says.

"It may be that they want to eliminate bonuses or equity compensation arrangements. It may be that they want to convert cash payments to equity payments, because they simply don't have the cash.

"Or it may be that they would rather tie the executive compensation to the performance of the company, instead of paying cash outright."

In the event your company wants to make these kinds of mid-year changes, Van Fleet says you need to measure those changes against the requirements of 409A.

"For example, maybe you have executives who are making $500,000 a year in cash, plus they have some deferred compensation arrangements. Let's say they made an election to defer some portion of the cash compensation, and now you decide to convert $300,000 of their cash compensation to equity compensation. What has that done to the deferral election? Is that an impermissible change?

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You need to evaluate existing deferral arrangements against 409A to see if you're creating any problems."

The second area of concern in executive compensation is design changes. "We're seeing employers want to scale back on their compensation packages. But 409A brings something new to consider, says VanFleet.

"For example, you may not be able to terminate and liquidate a plan because the company is in financial distress. If you want to make a payment under the deferred compensation plan, but it would cause the company to be in jeopardy as an ongoing concern if you make that payment, Section 409A says you can't make it.

"Unfortunately, the IRS (Internal Revenue Service) has never defined what it means by some of the terminology in 409A. It says, for instance, that if a company is experiencing a downturn in financial health, then there are restrictions on the company's ability to pay out deferred compensation.

"But it doesn't define what 'a downturn in financial health' means. Nearly every company out there, it seems, is experiencing a downturn in financial health right now," she adds.

"But without a litmus test, without a definition, must we assume that those companies are not allowed to pay out deferred compensation? Is there some kind of relativity test?

"The issues with [executive] compensation really are mostly 409A-generated," Van Fleet continues. "While we are seeing a lot of changes in the executive compensation area as a result of the current economic environment, the legal issues that are being raised are largely because of 409A.

"There aren't laws designed to protect executives the way there are laws to protect the rank and file workers; the executives are on their own.

"That's why it's ironic; the one impediment we're stumbling into is a law that was put in place, in effect, to punish executives."

VanFleet points out that "another big issue is company stock. It's always risky to have company stock in a plan, but in this environment even more so. People have their 401(k) monies, or other qualified plan monies in company stocks, and now there are concerns about investing in a stock that may have declined significantly in value recently.

"It's true with Employee Stock Ownership Plans, as well. And you also have stock valuation issues when plan assets are in company stock. We've seen some stocks decline by 50 percent over a 3-month period recently.

"When that happens, you have to be very careful about how you make payouts from the plan. When there are wild swings in the value of the stock, the payout you make to someone may be to the detriment of other participants," she cautions.

Decisions Are Urgent, But Take Your Time

As is often the case, the answer comes down to process and procedure—facts and circumstances, she says. "It's hard, because there is no safe harbor rule, no sense of comfort. You need to have good processes, good procedures in the absence of anything definitive to hang your hat on." And you should seek out good legal guidance, too.

The message, says Van Fleet, is that although the economy may require some quick decisions with regard to staffing, benefits, or compensation, don't be too quick to make them.

"These are urgent issues, but I'm seeing people make decisions that are not being vetted in the normal context that they otherwise would be—run by lawyers, run by consultants, run by the people in HR," she says. "Sometimes we're seeing these decisions being made by people responsible for the budget, rather than HR.

"Normally, employers think about design changes in a measured, systematic way. But in the last 6 months, because of the compelling economic environment, some are not taking their time and considering the implications of their decisions.

"How you implement the changes is important," Van Fleet explains. "If you don't think it through, you may end up without having saved any money at all. In fact, your decision may actually cost you more money, because you end up in noncompliance or being sued over it."

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Networking, Job Search Workshops Offered to Employees' Families

Who:	Astellas Pharma US, Inc.
What:	Launched a program to provide networking and career building workshops to employees' immediate family members.
Results:	Employees are proud to work for a company that cares about them and their families.

Given the economy, it is not unusual these days to hear about a company providing outplacement services to laid-off workers. However, it *is* unusual for a company to offer such services when it is maintaining—or even growing—its workforce.

But that's what Astellas Pharma US, Inc. (www.us.astellas.com) is doing. The mid-sized pharmaceutical company is hiring in most areas of the company, but officials noticed that many employees had family members who had lost their jobs with other employers, says Rod Christmon, director of Talent Acquisition, Diversity and Inclusion for Astellas.

In April, the company, which employs about 700 people in Deerfield, Illinois, launched networking and career-building workshops at its training center for employees' immediate family members who were out of work and didn't have access to outplacement or transitional services through their former employer, he says. In the future, the company plans to offer a similar workshop via webcast for family members of its 950 sales employees and other employees in the field, as well as additional workshops in Deerfield, if needed.

Quick Turnaround

The idea surfaced in late winter, as the national unemployment rate continued to climb, and Astellas officials heard how some employees' families were personally affected. "We just felt it was something we needed to do," Christmon says.

It took no more than 2 months to launch the workshops, according to Christmon. Astellas, which already had an existing relationship with a firm that provides executive coaching, career transition, and outplacement services, contracted with the firm to run two full-day workshops that were open to employees' spouses and children.

The company promoted the workshops via its intranet, an article in the company's monthly magazine, and an "e-mail blast" sent to all employees, he says.

Eighteen people participated in the first session, which was geared toward those who had at least 5 years of work experience before losing their jobs. Sixteen people with up to 5 years of work experience attended the second session.

Some of the family members participating in the workshops had 20 or more years of experience with their former employers and had no need to develop networking and job search skills over the years, he says. "They have not been active in the job market for quite some time."

The workshops taught them about writing résumés, aligning references to the jobs they apply for, building an effective network, networking with relevant organizations, managing their job search, creating a job search strategy and schedule, and staying positive during their search, according to Christmon.

He says family members who want to submit their résumés to him or his staff will receive feedback on fine-tuning their résumés. He also wants the family members to keep the company informed about how their job searches are going.

"The feedback from participants was phenomenal," Christmon says, noting that employees also expressed their appreciation for the company's efforts and their pride in working for an organization that cares about them and their family.

Christmon, who sat in on the first workshop himself, said the experience "really put a face on what we all see on the news everyday or read in the paper"—people working hard to find a job but not being sure how to go about it. "In order to find a job in this economy, you really have to have a strategy."

The workshops represent the company's latest efforts to support its employees by offering a comprehensive benefits package, according to Christmon. "We want to make sure our employees feel good at home and at work," he says, adding that stress at home could potentially impact employees at work. "Our most important asset is our employees. We want to make sure we're looking at employees holistically," he explains. Offering the workshops to employees' family members was "a no-brainer for us."

Tips to Consider

Here are a few tips for offering job search workshops for employees' family members:

Assess the need. Listen to your employees. Find out if their family members have lost jobs and whether they are struggling to find work.

Leverage existing partnerships. Many organizations have existing partnerships with firms that would be able to run job search workshops.

Consider the advantages. According to Christmon, the advantages to employees and their family members outweigh the costs of providing the workshops.

Benchmark. Christmon says employers may call him with any questions about providing job search workshops to employees' family members. He can be reached at 847-317-8801.

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Fee Disclosure Bill Proposed

Employees would receive clear and complete information about fees taken from their 401(k)-style accounts under the 401(k) Fair Disclosure for Retirement Security Act of 2009 (HR 1984).

The proposed legislation, which was referred to the House Committee on Education and Labor, would ensure that workers receive basic investment information—including information on risk, return, complete fees, and investment objectives—before signing up for a plan, according to bill sponsor Rep. George Miller (D-California).

Under the proposal, all fees charged against a worker's account would have to be included in the account holder's quarterly statement, and service firms would have to categorize for employers the fees workers are charged on all investment options (i.e., administrative fees, investment management fees, transactions fees, and other fees), a statement from Miller explains.

Although the ERISA Industry Committee, known as ERIC, expressed support for enhanced fee disclosure in a statement to the House committee, it called for a "comprehensive rewrite" of the bill and warned that, in its current form, the bill would "create a complex fee disclosure regime that would ultimately confuse participants and dramatically increase the litigation risks already facing 401(k) plan sponsors."

Larry Goldbrum, general counsel of The SPARK Institute, criticized the bill's "one-size-fits-all" requirement for detailed disclosures about plan fees and expenses in predetermined categories, among other things.

A similar bill (S 401) was introduced in the Senate and referred to its Committee on Health, Education, Labor, and Pensions.

Minimum Wage Hike

The third of a three-step increase in the federal minimum wage goes into effect on July 24, 2009.

Under legislation enacted in 2007, the minimum wage for nonexempt workers rose for the first time in a decade—from $5.15 per hour to $5.85 in July 2007, and then to $6.55 in July 2008. Effective July 24, 2009, the federal minimum wage will increase to $7.25 per hour. That marks a $2.10 increase per hour over the past 26 months.

Compensable Training Time

Do you have to pay workers for the time they spend in training? That depends on the situation.

In three recent opinion letters (FLSA2009-1, FLSA2009-13, and FLSA2009-15), the U.S. Department of Labor's Wage and House Division (WHD) outlined four criteria for determining whether training time is compensable. Under 29 CFR 785.27, "[a]ttendance at lectures, meetings, training programs, and similar activities need not be counted as working time if the following four criteria are met":

1. Attendance is outside the employee's regular working hours;
2. Attendance is, in fact, voluntary;
3. The course, lecture, or meeting is not directly related to the employee's job; *and*
4. The employee does not perform any productive work during such attendance.

In FLSA2009-1, WHD stated that the time spent by childcare center employees in state-mandated training programs, offered by the employer and required for employees to maintain state certification, does not constitute hours worked under the Fair Labor Standards Act. Based on the information submitted, the training meets all of the criteria above, according to the Opinion Letter.

However, in FLSA2009-13, WHD indicated that the time technicians spent taking four 10-hour, Web-based prerequisite classes at home in preparation for a voluntary, job-related training class is, in fact, compensable, because the classes are directly related to the employees' job.

In FLSA2009-15, WHD found that city employees must be compensated for the time they spend studying for city-required training, because the criteria in items 1, 2, and 3 above are not met.

The Opinion Letter also states that the city may limit the amount of time employees spend studying; however, if they exceed the allotted time, "the time may be compensable."

IRS Update

401(k) Guidance Issued

Recent guidance from the Internal Revenue Service (IRS) provides insight into automatic contribution and automatic enrollment arrangements for 401(k) plans.

Final regulations issued by the IRS affect administrators of, employers maintaining, participants in, and beneficiaries of 401(k) plans and other eligible plans that have an automatic contribution arrangement [*Federal Register*, Vol. 74, No. 25, 2/24/09].

Among other things, the guidance addresses requirements regarding minimum default contribution percentages, uniformity, notice timing, and the exclusion of current affirmative elections from automatic enrollment.

Small employers can learn more about automatic enrollment arrangements in "Automatic Enrollment 401(k) Plans for Small Businesses," a free publication from the IRS and the U.S. Department of Labor.

The booklet, which provides a comprehensive overview of the advantages of starting and operating this type of 401(k) arrangement, is available through the Employee Benefits Security Administration by calling 866-444-3272 or visiting www.dol.gov/ebsa.

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Experts' Forum

Single vs. Multi-Vendor— The Critical Decision in 403(b)

by David Ray, Diversified Investment Advisors

Of all the fallout of the new Internal Revenue Service (IRS) 403(b) regulations, probably the most important and pressing decision that not-for-profit (NFP) plan sponsors are facing is the decision over how many active service provider relationships to maintain. While plan sponsors struggle over this decision, plan providers are actively lobbying for the outcome that aligns best with their own solutions.

The simple fact is that multi-vendor relationships are a carry-forward from a by-gone era. The market has evolved, and "open architecture" investment platforms have become the standard, rendering most multiple vendor platforms inefficient at best and useless at worst.

In certain segments of the NFP market, such as higher education, plan sponsors have been with the same provider for many years, and while due diligence would suggest the need to place their plan out to bid with some frequency, they have elected not to. They have pinned their hopes and fiduciary obligations instead on the guidance and services offered through the predominant vendor(s), with little regard to their duties of plan oversight and management. The IRS 403(b) regulations have awakened them to the reality of their plight and many are now looking for new alternatives in a world driven by fiduciary risk.

With these facts in mind, it begs the question: *Why maintain multiple vendor relationships anymore?*

Plan Compliance

By now, all NFP plan sponsors are aware of the new requirements of the IRS 403(b) regulations. The days of simply being a "payroll conduit" and sending deferrals to different providers with no further liability are over. Plan sponsors face new compliance requirements that carry significant penalties from the IRS for noncompliance. In a multi-vendor world, plan sponsors can expect compliance requirements to increase exponentially by the number of vendors utilized.

Furthermore, if the 403(b) plan is covered by ERISA and has over 100 employees, you will be required to file a complete 5500 form on an annual basis for plan years on or after January 1, 2009, and a yearly audit of the plan will also be required. Extra work and extra time (therefore, extra fees) will likely be required for that audit due to multiple vendors.

Information Sharing

Providers in the marketplace are selling aggregator/gatekeeper/common remitter functionality that they would have you believe solves information sharing. Do they? That question remains to be answered as the regulations are new and these platforms haven't been properly tested or audited.

The simplest way to comply would be to utilize a single-vendor and consolidate all plan assets and participant records with that vendor. That way, information-sharing agreements and gatekeepers would not be necessary. Is that possible? It depends on the vendor contracts and how the rights of those agreements are vested. Plan sponsors should review these thoroughly to determine their rights in discharging their duties as plan fiduciaries.

The Participant Experience

Arguably, the most compelling reason to go with a single-vendor service model is to enhance the participant experience. In a multi-vendor environment, vendors are competing with one another for participant contributions and account balances. Simple transactions, such as loans and exchanges, are greatly complicated for plan participants as a result of asset retention efforts.

Investment redundancy is also an issue for plan participants since many vendors offer similar (if not the same) investment options. Numerous industry surveys have found that more choice is not always better for participants. They become overwhelmed and are more likely to not participate in the plan or to under-participate, by not engaging in planning exercises, deferring too little, and being improperly diversified.

Participant education is all too often negatively impacted in a multi-vendor environment. Virtually any education that happens is a by-product of a sales pitch from vendors competing for employee accounts. Many plan sponsors perceive employees will be upset if "their" vendor is eliminated. However, experience suggests this concern is greatly overstated.

Economies of Scale

Higher costs have been the single biggest downfall of multi-vendor models; i.e., splitting contributions and participant balances among several vendors has resulted in higher fees and lesser services for both the plan sponsor and participant. ERISA budgets (created from excess investment revenue) are popular cost methods for offsetting plan expenses. Unfortunately, many vendors, especially in the NFP market, have not been willing to make this cost-saving feature available, preferring to extract the highest fees possible.

Plan sponsors, their advisors, and providers will no doubt debate the pros and cons of both relationship models for some time to come. Those debates should never lose sight of the intended benefactor of these discussions—the plan participant.

For fiduciaries, a core best practice involves benchmarking their retirement plan periodically against industry standards, typically through an RFP (request for proposal) process. Based on an examination of plan compliance, participant education, or today's competitive service offerings, plan sponsors should ask themselves which vendor model represents the best solution. The likelihood is that sponsors will recognize a single vendor relationship presents fewer pitfalls and more advantages than multi-vendor relationships were ever intended to offer.

David Ray is vice president and national practice leader for not-for-profit & public sector markets and regional sales manager for Diversified Investment Advisors. In that capacity, he leads the company's not-for-profit sales and product development efforts. As regional sales manager, he leads the sales efforts for the West Coast.

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From the Courthouse

Must Administrator Disclose Documents Used to Justify Claim Denial?

A federal appeals court has imposed fines on the administrator of a self-insured health plan for failing to provide a claimant with the plan documents that were the basis for denying her claim.

The court ruled that it did not matter that the documents in question were actually not binding on the administrator and had been relied on improperly (*Mondry v. American Family Mutual Insurance Company*, U.S. Court of Appeals for the 7th Circuit, No. 07-1109, (2009)).

Facts. While working for American Family Mutual Insurance Company, "Molly" sought reimbursement from the company's health plan for speech therapy for her son. Claims administration for the plan had been contracted out to CIGNA HealthCare. The plan's summary plan description (SPD) stated that speech therapy was covered if performed by a licensed or certified therapist who was referred by a doctor and was determined to be medically necessary.

In January 2003, Molly contacted American Family to find out how much of her son's therapy would be covered and was directed to the plan's SPD. Based on the SPD, she took her son to his first therapy session and to regular sessions thereafter.

However, CIGNA later denied coverage because the plan covered restorative, but not educational, therapy. The denial cited CIGNA's Benefit Interpretation Resource Tool for Speech Therapy (BIRT).

Molly wrote CIGNA and American Family appealing the denial and requested governing plan documents. CIGNA rejected the appeal because the therapy was not restorative and was not covered under specific provisions of the plan, citing the CIGNA Clinical Resource Tool (CRT) for Speech Therapy.

Molly secured the services of a public interest law firm, Advocacy and Benefits Counseling for Health, Inc. (ABC).On September 23, 2003, ABC requested that the governing plan documents be provided within 30 days. American Family responded on October 16, 2003, that the enclosed SPD was the plan document. ABC then wrote to CIGNA asking for confirmation that the SPD was the legally binding plan document and, noting that the CRT was not part of the SPD, requested a copy of it. CIGNA responded that the SPD had to be obtained from American Family and did not mention the CRT.

Twice more, ABC asked CIGNA and American Family for any plan document that included the language that CIGNA relied on to deny the claim and for a copy of the legally binding plan document and the CRT, but CIGNA denied the request for the CRT because it was an internal CIGNA document. In July 2004, ABC finally got a copy of the CRT from CIGNA because the CRT was going to be applied to Molly's level two appeal. However, the CRT did not contain the language that CIGNA cited in denying the claim and the level one appeal.

ABC again requested any and all documents containing the relevant language. CIGNA responded that the appeal decision would be based "on the SPD, the plan contract, the general service agreement, and CIGNA's criteria." Meanwhile, ABC received a copy of the BIRT that listed 14 types of outpatient speech therapy that would not be covered including "speech therapy that is not restorative in nature."

In April 2005, CIGNA's appeals committee ruled that Molly's claim had been denied improperly. Molly filed suit claiming that American Family and CIGNA were liable for fines for failing to produce plan documents when they were requested.

The LAW

Employee Retirement Income Security Act

ERISA Sec. 104(b)(4) provides that, upon written request of any participant or beneficiary, a plan administrator must furnish a copy of the latest updated SPD; the latest annual report; any terminal report; and the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.

ERISA 502(c)(1) provides that a plan administrator who fails or refuses to comply with such a document request within 30 days may, at the court's discretion, be personally liable to the participant or beneficiary for up to $110 a day from the date of the failure or refusal (unless the failure or refusal results from matters reasonably beyond the control of the administrator).

Ruling. The court determined that the failure to provide the CRT and BIRT would be a violation ERISA Sec. 104 if those documents were instruments under which the plan was operated.

The court noted the U.S. Department of Labor (DOL) position that any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a benefit entitlement is such an instrument. On the other hand, courts have ruled that internal guidelines and memoranda do not constitute plan documents if they are used as nonbinding, internal interpretative tools.

The court resolved this conflict by looking to a claims procedure provision from ERISA Sec. 503 that requires a full and fair review of claim denials.

DOL regs provided that a full and fair review requires that claimants have

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Benefits Corner

Small Changes to Health Plan, Big Improvements in Employee Health

"A lot of folks don't understand their health benefits and their pharmacy benefits as well as they could," says Ed Pezalla, M.D., medical director of Aetna's Pharmacy Management Program. That incomplete understanding impacts employee health much more than you might suspect. And what impacts employee health impacts your company's healthcare dollars.

Pezalla suggests some minor changes you can consider that could potentially help your company save money by improving the health of your employees. The first is to recognize that employees can't use their benefits effectively if they don't understand them. "These things are very complicated," he says, "and most people only think about them once a year when they go to sign up for their coverage.

"It really does help people to be reminded about their benefits and how to use them wisely. Open enrollment time is hard, because people have so many things to do already: enroll in their 401(k) or their Roth IRA, decide about dental benefits and whether or not their spouse should have life insurance. These are all complicated things that require a lot of research people may not have time for. So it may be better, once that is all over, to take a little bit of time to educate people about how their benefits work."

When things have cooled down from open enrollment season, take advantage of the lull to educate employees about how they can save money with benefits they already have. For example, says Pezalla, many people don't understand that they may have first-dollar coverage on some treatments when they're covered by a high-deductible plan.

"Often, things that are considered preventive care are covered right away, without a deductible," he says. "We have a list of medicines that fall under that preventive care rule, so members of Aetna who have high-deductible plans can get coverage right away. The same applies for some things on the medical benefits, too, like mammography and other screening tests that are important." Check with your medical plan provider to find out if your plan also offers first-dollar coverage for preventive measures.

"Generic drugs save significant money for employees and the employer. Their use can sometimes be increased by educating employees about the benefits of using them. "There are many good generic drugs now in a lot of different categories. At one time, they were the big brand-name products, and they have not lost their efficacy just because they're generic.

"Generics are so much less expensive than branded drugs that, where it is appropriate for people to switch—and of course, they should always check with their doctor—that can really save money for them and for their plan sponsor."

Reward Activities, Reap Benefits

Can you save money by rewarding employees for participating in health-related activities? Ed Pezalla, M.D., of Aetna's Pharmacy Management Program says that sometimes you can. "Reward programs can be useful especially in a setting where you're trying to get people to do something one time.

"If a member fills out a health risk assessment, gets his or her cholesterol and blood pressure checked, or even goes to your website to learn more about the tools you have there to help with their health, then having some kind of reward for them doing that is really terrific. But, what you really want is for them to be motivated toward healthy ongoing behaviors on their own.

"If there is something you want people to do over time, like take their medication every day, you want them to internalize that activity—because they want to stay healthy, because they want to see their grandkids graduate from college, because they want to be able to play baseball—whatever it is that motivates them personally.

"If you offer external rewards, you get in the way of them developing that internal motivation."

ABOUT THIS NEWSLETTER

This newsletter is devoted to sharing compensation and benefits ideas that have worked for HR professionals striving to make a strategic difference in their companies. If you have a story you'd like to share, send us a fax at 860-510-7224.

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CASE Study Study Study Study

VEBA Saves Money, Provides Better Quality Through Second Opinion Service

Who: Southern California Schools VEBA

What: Contracted with Best Doctors, who review diagnoses and treatments of members who so request

Result: Found that nearly 1-in-5 diagnoses were incorrect, and $40 million was being spent on unnecessary medical care for their members

When people are asked to rate other drivers, most won't hesitate to say that a large percentage of those they share the road with are bad drivers. But when they are asked to rate themselves, the vast majority will say that they consider themselves to be above average drivers. The same phenomenon seems to apply to many people when it comes to how they view doctors. George McGregor, president of benefit consultants McGregor & Associates, illustrates.

"When I speak to large groups, I usually start by asking how many people think there is a healthcare crisis. Everybody in the audience raises his or her hand. The second question I ask is how many think there is a quality crisis, that there is bad quality being provided in the healthcare delivery system. Everybody raises hands. The third question I ask is, How many of you see a bad quality physician? Nobody's hands are raised."

McGregor is not trying to impugn the reputations or abilities of all physicians. He is, however, attempting to point out that individuals have a right and a responsibility to oversee their own medical care. "I use those questions to demonstrate that we are all part of the problem," he says, "in that we tend to believe our physician is infallible, and simply rely on what he or she says without questioning and without being responsible for our own health care."

McGregor is the administrator for the Southern California Schools Voluntary Employee Benefits Association (VEBA), a cooperative labor-management trust program for education employees in Southern California. The VEBA includes employees of 30 school districts, one association, and the county office of education, and it covers roughly 82,000 members, including employees and their dependents.

Due in part to geography, McGregor says the medical community in the San Diego area operates something like a cartel. "San Diego has a unique problem in that it is bordered by a foreign country to the south, it has uninhabitable desert to the east, and a military base to the north. It is isolated from a healthcare perspective. There are very few healthcare providers, and those providers believe that you can't go anywhere else for your health care. Consequently, we're seeing 30 percent year-over-year increases in actual cost of health care. Obviously, that becomes unaffordable very rapidly."

As costs skyrocketed, though, VEBA members were not getting healthier, McGregor says. "In fact, we felt that the morbidity of the population was actually increasing, not decreasing. It appeared to us that we were spending more and more money on health care, but getting less and less from it," he says. The VEBA decided to engage the services of Best Doctors (www.bestdoctors.com), a health benefits service that helps people access top medical specialists to review their medical cases.

Better Quality Means Lower Costs

Long-term healthcare cost control must come through improvements in quality, McGregor believes. "You can always do cost-shifting techniques, but that doesn't help with the ultimate purpose of controlling costs long term, which comes from controlling quality," he says.

"We want to get people well, and keep them out of the delivery system. Best Doctors told us to expect that one-in-five of our diagnoses would be incorrect, and that 60 percent of the health care for our chronic users, even in cases where there was a correct diagnosis, would be using old medical treatments. We engaged them to do a study, and what we found was that 18 percent of our diagnoses were wrong. That was a little better than they expected to find.

"But more than 70 percent of the treatments for our members with an accurate diagnosis were old medical treatments—there were better medical treatments out there. What that translates into for the VEBA is they were spending $40 million a year treating diseases that the members don't have."

For roughly $3 per member per month, Best Doctors provides members with access to top specialists they might otherwise be unable to reach. While this is an added cost to the plan sponsors, they have had a return-on-investment of nearly 4-to-1. "Not to mention several saved lives," McGregor reports.

Chart Review Reveals Problems, Saves Life

One of those lives is someone with whom McGregor has worked for nearly 20 years. Fifteen years ago, he says, Barbara was diagnosed with

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breast cancer and underwent a double mastectomy. At the time, doctors told her she had 6 months to live. McGregor says they she became a test case to see how Best Doctors could improve quality. "They found out that she had bone cancer that had gone untreated over that time frame," he says, "and that there was evidence of that in her medical records, which was ignored by the medical delivery system.

"The review found that the treatment her doctors had recommended for the resurgence of her cancer was ineffective for the kind of cancer she actually had. Best Doctors got her daughters genetically tested and found that one of them had the gene predisposing her to the disease, so they can work proactively to keep her from getting it.

"Barbara took the report from Best Doctors in to her own oncologist, who said, 'I don't need anybody telling me how to practice medicine.' Then he looked at the name of the person who signed the report and saw that it happened to be one of the foremost cancer experts who had recently been published in the authoritative literature. He took the report and stapled it on the outside of her chart to review."

Members who are diagnosed with a serious illness have the option of utilizing Best Doctors when it is offered by their health plan. When they do use it, Best Doctors performs an extensive review of their medical records, as was done for Barbara, and provides a recommended treatment plan.

In cases where the physician is unwilling to participate, Best Doctors locates a quality physician who specializes in the diagnosed condition and who is within the insurance network.

"The insurance company benefits because people are getting properly diagnosed and treated, and it's all done within the network through contracted providers," McGregor says.

Although at this writing Best Doctors is available only to groups of 5,000 or more, McGregor is working with the company to offer it to consortiums of small employers.

McGregor says that, as a result of the last decade or so of cost-sharing and rapidly increasing healthcare costs, employees tend to be skeptical about suggestions from their employer. "People may think that the program is something being suggested by their employer simply to reduce costs," he says.

"Companies need to find employee champions to help implement the program. When I was out telling people about this, I couldn't get anybody to pay attention.

"So at our annual advisory meeting, I had Barbara come and speak to the 100 business people who deal with benefits in multiple employer trusts. She told her story personally, and I literally got backed into a corner with 40 people demanding information on the program.

"Hearing somebody, in their own words, talk about a misdiagnosis and how the delivery system failed her, humanizes it." If you'd like to hear Barbara's story in her own words, you can see her video at www.vebaonline.com.

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"reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits." Under this approach, a document is "relevant" and must be disclosed if it "was relied upon in making the benefit determination."

Had CIGNA privately relied on the CRT and BIRT as reference materials to guide its interpretation and application of the plan language, these documents would not have to be disclosed. But, because CIGNA did not treat the BIRT and CRT as private guidelines that merely illuminated plan language and expressly cited both documents as the basis for its decision to deny Molly's claim, their disclosure would be necessary for a full and fair review.

Q: We have reduced hours for our hourly employees and believe it would be fair to do the same for our salaried employees. Is it possible to do so without impacting their exempt status?

A: Within certain parameters, you may reduce hours (and therefore, pay) for your exempt, salaried employees.

We asked BLR's Managing Legal Editor, Catherine Moreton Gray, J.D., who said:

"Under the federal Fair Labor Standards Act (FLSA), exempt employees must be paid a fixed weekly salary of not less than $455 per week regardless of the number of hours worked each week.

"In the situation you describe, the company could reduce the workweek to 32 hours/4 days and make a corresponding reduction in the exempt employees' weekly salary but must take care the weekly salary doesn't go below $455. If it does, the employees would no longer be exempt."

Before making the decision, though, Moreton Gray cautions that you make sure any union contracts are considered, since pay and hours are often the subject of bargaining agreements.

It would also be wise to review any individual contracts or policies related to salaries.

Pay, Staffing Cuts: Is the Worst Over?

You may be afraid to take your next breath, wondering if your company has weathered the worst of the Great Recession. In the first—admittedly guarded—good news that we've seen for awhile, a recent survey of U.S. employers would seem to indicate that you may resume breathing almost normally.

Watson Wyatt conducts an ongoing series of employer surveys. The results of their April survey of 141 employers, released April 21, 2009, did show that some companies are continuing to adopt cost-cutting measures like salary reductions and workweek reductions. But the survey found that plans for these kinds of measures for the subsequent 12 months have decreased across the board.

Most of the surveyed companies seemed to be optimistic in their plans. For example, 67% said they are planning no further hiring freezes; 65% reported they will undertake no further organizational restructuring; and 53% were not planning further layoffs.

The good news is tempered by the situation we've already been experiencing: although the majority of the surveyed companies are not planning further salary reductions (89%) or salary freezes (76%) in the next year, the number that has already made these changes has risen sharply since the last survey in February 2009. Mandatory shutdowns (24%), reduced workweeks (22%) and mandatory furloughs (17%) also rose sharply since February.

"Companies have started to move into the next stage of their cost-cutting actions, but are also looking ahead to an eventual recovery," said Laury Sejen, global director of strategic rewards consulting at Watson Wyatt. "There is a recognition that employers will need to be poised for a turnaround, and that continuing some cost-cutting measures such as reductions in force can put them at a disadvantage once the economy improves."

For some companies, merit raises may even be on the horizon. According to the survey, merit pay increases are expected to remain at 2% in 2009, but will increase to 3% in 2010. Short-term incentive funding plans have not changed drastically in the last 2 months, either. In February, companies planned to fund their short-term incentive plans at 71%, compared with 69% in the latest survey.

Companies had reduced their 401(k) matching contributions since the February survey, as well. In April, 22% of surveyed companies reported they would reduce their match, compared with 12% 2 months earlier.

There was also a slight increase in the number of hardship withdrawals taken from 401(k) plans: 44% said in April that they had seen an increase in withdrawals, compared with 35% reporting the same in February.

For more information about the survey, visit www.watsonwyatt.com.

As Insurance Fears Loom, Employee Utilization Increases

According to the International Foundation of Employee Benefit Plans (IFEBP), increased cost-sharing measures in employee health insurance have resulted in higher utilization among employees.

"Plan participants are feeling anxious about the possibility of increased cost-sharing and a reduction in benefits due to the financial crisis," said Sally Natchek, CEBS, senior director of research for the IFEBP. "These fears are not unfounded."

While a small minority (3.6%) of plan sponsors are cutting, or considering cutting, their healthcare benefits entirely, many others are increasing their cost-sharing techniques. Deductibles, coinsurance or co-pays are increasing for 35% of employers surveyed, and nearly as many are also increasing employee premiums. Also, 12.8% of the surveyed employers are implementing consumer-driven health plans as an option, and 9.6% will replace a current plan with a consumer-driven plan. In addition, 10.8% will begin charging for spousal coverage.

Participants seem to be reacting to these changes in one of two ways. The IFEBP says that, according to their survey, plan participants are increasing their utilization of their health plans, perhaps fearing an impending layoff.

About one-third of the plan sponsors noticed an increase in the number of participants filling prescriptions and engaging in costly medical procedures, and 24% have noticed growth in the number of participants adding dependents to their plans.

However, about one-fifth of respondents said their plan participants are delaying medical care and skimping on prescription drugs because of financial problems.

"The financial crisis has led some to conclude that health care and the economy are inextricably linked," said Natchek. "You can't separate one from the other. Given the burden of growing healthcare costs, it's likely that healthcare reform will continue to be at center stage.

And 85% of responding plan sponsors believes that the financial crisis has made major federal reforms more likely."

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A Closer Look at ARRA's Continuation Benefits Subsidy

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), when an employee who is a "qualified beneficiary" (an individual covered by an employer's group health plan) leaves the company as the result of a "qualifying event" (voluntary or involuntary termination for reasons other than gross misconduct), employers of 20 or more employees must offer the departing employee, as well as a spouse or dependent child of the employee, the right to continue for a period of at least 18 months (at the employee's expense) the same health insurance coverage the employee had under the employer's group health plan.

The plan is not required to charge qualified beneficiaries for their continuation coverage; COBRA rules do, however, set the upper limit for the premiums a plan is allowed to charge at 102% of the employee's cost.

The employer has various "notification requirements" under COBRA. For instance, it must notify each employee and his or her spouse of their COBRA rights as soon as the employee joins the group insurance plan. Upon the occurrence of a qualifying event causing the loss of an employee's coverage, the employer must notify the plan administrator within 30 days.

Within 14 days of being provided with such notice, the employer, if the plan is self-administered, must provide each qualified beneficiary with a notice that explains the beneficiary's right to elect COBRA continuation coverage, the coverage that may be elected, the duration of the coverage, and how much the coverage will cost and how and when it must be paid.

COBRA Provisions in the 2009 Recovery Act

Some of the COBRA provisions in The American Recovery and Reinvestment Act of 2009 (ARRA), signed by President Obama on February 17, 2009, are as follows:

Reduction in premiums for AEIs. ARRA defines an assistance eligible individual (AEI) as any "qualified beneficiary" under COBRA who is eligible for COBRA continuation coverage at any time from September 1, 2008, through December 31, 2009, as the result of a "qualifying event" occurring during this period, and who elects continuation coverage.

ARRA provides that for a period of not more than 9 months, such AEIs are treated as having paid any premium required for COBRA continuation coverage under a group health plan if the AEI pays 35% of the premium; so, the AEI is effectively entitled to a subsidy for 65% of the premium.

Reimbursement of employer. ARRA provides a mechanism for reimbursing the person to whom premiums are payable for the difference between the full premium and the 35% paid by an AEI.

The person to whom premiums are payable and, therefore, the person entitled to reimbursement, is the employer in the case of a group health plan which is not a multiemployer plan and which is subject to the COBRA continuation coverage provisions contained in Internal Revenue Code, ERISA, Public Health Service Act, or civil service provisions of the U.S. Code, and under which some or all of the coverage is not provided by insurance.

An employer entitled to reimbursement and that files a claim for reimbursement at such time and in such manner as the Internal Revenue Service (IRS) requires will be treated as having paid payroll taxes in an amount equal to the portion of the reimbursement relating to that premium. To the extent that the amount treated as paid exceeds the amount of the employer's liability or payroll taxes, IRS will credit or refund the excess in the same manner as if it were an overpayment of payroll taxes.

Continued Health Coverage Under State Law

Small employers not subject to COBRA rules because they have fewer than 20 employers may still have COBRA type responsibilities under state law, according to a recent article in the *New York Law Journal,* which examined the situation in the state of New York (Steven J. Glaser, *Health Coverage for Terminated Employees Under New York Law*, May 6, 2009).

According to the *Journal* article, upon termination of employment or other events typically triggering continuation coverage under COBRA, New York's Insurance Law requires insurance companies and HMOs issuing group health contracts to provide for continued coverage of terminated employees, and their dependents, under a group policy for essentially the same periods and under the same conditions as COBRA coverage.

Thus, rather than directly regulating employers, as is generally the case with COBRA, New York's continuation privileges are imposed through the mechanism of regulating the contents of insurance policies and HMO contracts issued in New York.

So, what are the obligations of employers with respect to such policies and contracts?

The article contends that although the state's Insurance Law deals only with the contents of group policies rather than the affirmative obligations of employers as group policy

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holders in administering such policies, a regulation issued by the Insurance Commissioner appears to have imposed an obligation on employers to give notice of continuation coverage under a group policy within 14 days after an employee terminates service or the employer receives notice from the employee of another qualifying event.

The article also cites the decision of a New York court recognizing a common law duty of an employer to give notice to an employee of his conversion rights under a group health policy.

The court held the employer liable for medical expenses that its former employee incurred within the 90-day period during which the conversion privilege could have been exercised had notice been given (See *Antinora v. Nationwide Life Insurance Company*, 350 NY Supp 2d 863 (1973)).

What to Remember

The COBRA provisions of ARRA must be studied carefully because they create more notice requirements for employers subject to COBRA. ARRA does not change the fact that only employers of 20 or more employees are subject to COBRA. However, under state law, employers may have obligations to give employees notice of their rights under group insurance policies.

BLR's Pay Conversations Audio Conference July 13

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By the numbers...

	Latest Period	Current	Prior Report	A Year Ago	12-Month % Change
CPI-U	Apr/09	213.2	212.7	214.8	-0.7%
CPI-W	Apr/09	207.9	207.2	210.7	-1.3%
ECI EMPLOYMENT COST INDEX					
Total Compensation	1Q/09	109.3	108.9	107.3	1.9%
Wages and Salaries—Private Industry	1Q/09	109.8	109.4	107.6	2.0%
Wages and Salaries—Civilian Workers	1Q/09	110.0	109.6	107.6	2.2%
Benefits	1Q/09	109.7	109.1	107.6	2.0%
Average Weekly Gross Wages*	Apr/09	$614.53	$614.20	$606.37	1.3%
Average Hourly Wages					
All*	Apr/09	$18.51	$18.50	$17.94	3.2%
Construction	Apr/09	$22.45	$22.46	$21.49	4.5%
Manufacturing	Apr/09	$18.14	$18.09	$17.64	2.8%
Trade/Transp./Utilities	Apr/09	$16.41	$16.43	$16.13	1.7%
Wholesale Trade	Apr/09	$20.70	$20.66	$20.01	3.4%
Retail	Apr/09	$13.02	$13.01	$12.89	1.0%
Financial Activities	Apr/09	$20.66	$20.70	$20.21	2.2%
Other Services	Apr/09	$16.30	$16.34	$16.09	1.3%
Unemployment Rate*	Apr/09	8.9%	8.5%	5.0%	3.9%

*seasonally adjusted
(**Source:** Bureau of Labor Statistics, Washington, D.C.)
All figures are national.

CPI-U: Consumer Price Index for all urban consumers; the newer index representative of the buying habits of about 87% of the total U.S. population. (1982–84=100)

CPI-W: Consumer Price Index for urban wage earners and clerical workers; the older index covering only about 32% of the U.S. urban population.

ECI: Measures change in compensation per hour worked, including wages, salaries, and employer costs of benefits. (6/89=100)

Average Weekly Gross Wages and Average Hourly Wages: Data related to production workers in manufacturing and mining; construction workers; nonsupervisory workers in transportation, public utilities, and wholesale/retail trade; also finance, insurance, real estate, and other services. Accounts for approximately 80% of the total employees on private, nonfarm payrolls.

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