



IRS Guidance on Deferred Compensation Presents a Mixed Bag

by Dominick Pizzano

The IRS issued its much anticipated second round of guidance for nonqualified deferred compensation plans (NDCP) recently, offering many unexpected treats to savor, but also some tricks for the unwary and absolute frights for the administratively squeamish. This article lifts the intimidating mask of the new proposed rules under section 409A of the tax code in an effort to reveal the compliance tasks now faced by plan sponsors. A comprehensive analysis of the complex and extensive new guidance is beyond the scope of this article; it focuses instead on four bedeviling D's: Definitions, Deferrals, Distributions, and Deadlines. Awareness of these issues will enable NDCP sponsors to begin developing an action plan for eschewing the tricks and not missing out on those treats that go stale after December 31, 2005.

Definitions—Coming to Terms with 409A

The initial step to 409A compliance requires that organizations know the “ins and outs” of who's covered and what constitutes a “409A plan.”

Who's covered? To accurately capture all individuals who could be subject to 409A, the rules do not refer to “employees” but rather to “service providers” (SPs). Likewise, the regulations refer to “service recipients” (SRs) in lieu of “employers.” Thus, in addition to employee/ employer relationships, 409A may apply to directors, independent contractors, partners, and personal service corporations or similar entities. SPs that are not employees and that serve two or more unrelated entities may be exempt from 409A under certain circumstances.

What's the Plan? Because the rules require not only operational compliance but also a written plan document that complies with the law, immediately identifying all such programs is critical. A 409A plan is any plan that creates a legally binding right under which compensation is deferred from one tax period to another. Therefore, any arrangements providing for the future payment of taxable benefits are potentially subject to the new rules unless they are specifically exempted. The new guidance retains the IRS's previous exemptions for qualified employer plans (including, but not limited to, 401(k), 403(b), and 457(b) plans, as well as profit-sharing, money purchase, and defined benefit pension plans) and certain welfare plans (such as any bona fide vacation leave, sick leave, compensatory time, disability pay, or death benefit plan). Furthermore, the proposed regulations grant exceptions for foreign plans, nonemployee arrangements, reimburse-

ments of expenses, and split-dollar life insurance plans that meet certain specifications. The new guidance also revisits the status of severance pay and short-term deferrals under 409A:

- *Severance Pay*—The IRS refused to provide the most requested treat: a total exemption for severance pay. However, the rules exempt separation pay arrangements from 409A if: a) the total pay to an SP does not exceed two times the lesser of (1) the SP's prior year's pay or (2) \$210,000 (i.e., the qualified plan dollar limit on compensation, which increases to \$220,000 in 2006); and b) all payments are made by the end of the second calendar year following the year in which termination occurs. Other exempted separation pay plans include collectively bargained plans, small payments (\$5,000 or less), and certain reimbursements for reasonable business expenses, outplacement expenses, and moving expenses.
- *Short-Term Deferrals*—The IRS's previous guidance providing a temporary short-term deferral exception (i.e., amounts paid within two-and-a-half months after the later of the SR's or SP's taxable year in which the amounts become vested) is made permanent. Furthermore, SRs have the option to forgo establishing a written plan document requiring *in all cases* that amounts be paid within the two-and-a-half month period deadline. However, without a payment date specified in a plan document, payments that are not paid out by the deadline will automatically be deemed a violation of 409A. In contrast, certain rules generally permitting a delay in payments to the fixed payment date (as described below) become applicable if the payment deadline is formally stated in the plan.

Deferrals: Exorcizing the Election Day Demons

In general, NDCP participants who wish to defer a portion of their pay for a given year must make their elections no later than December 31 of the immediately preceding taxable year. An exception applies for employees who become eligible mid-year: they have 30 days from the date of initial eligibility to make a deferral election. Missing this deadline forces participants to wait until December 31 to defer pay for the next calendar year. The new guidance permits NDCPs two deferral election alternatives: require participants to make a new election annually; or mandate that elections remain in effect unless changed. While the latter, “evergreen

election,” is administratively simpler, it demands proper communications because once the new year starts, the deferral election is generally irrevocable for that calendar year. Accordingly, NDCP sponsors taking this route should remind participants of the December 31 election deadline for the upcoming year’s deferrals during the last quarter of each year.

Another exception to the general timing rules applies to *performance-based pay* (i.e., compensation that is contingent on the satisfaction of preestablished organizational or individual performance criteria). If such pay covers performance over a period of at least 12 months, the participant’s initial deferral election may be made as late as six months before the end of the period (e.g., for calendar year plans, the participant could wait until June 30 of a given year to make an election to defer performance pay attributable to that year). The performance criteria may be established up to 90 days after the commencement of the period of service to which the criteria relates, provided the outcome is not substantially certain at the time the criteria are established.

The IRS also provides helpful guidance on two previously controversial aspects of the interplay between the NDCP and 401(k) plan deferral rules. While initial IRS guidance seemed to doom the future of NDCPs that involved coordination with the restrictions applicable to qualified 401(k) plans, the new guidance specifically authorizes the continued use of these “wrap plans,” but only to the extent the amount of affected deferrals (and matching contributions on such deferrals) under the NDCP does not exceed the maximum amount that ever could have been electively deferred under the 401(k) plan. The other obstacle was the 401(k) hardship withdrawal requirement that participants cease deferrals from *all plans* (including a NDCP) maintained by the sponsor. This presented a problem for employees who also had NDCP deferrals, because the NDCP deferral election was irrevocable for the year in which it was made. The new guidance eliminates this “Catch-22” by permitting a NDCP to terminate deferral elections if a SP receives a financial hardship distribution from the employer’s 401(k) plan. In addition, the regulations allow for the NDCP election to be terminated if the participant receives an unforeseeable emergency withdrawal from the NDCP.

Distributions: The Devil is in the Details

NDCP payments may only be made upon specified triggering events: separation from service; disability; death; an unforeseeable emergency; a change of control; or a date irrevocably designated at the time of the deferral elections. NDCP documents must clearly state how benefits will be distributed and/or the extent to which participants have discretion over the timing and/or form of the distributions. If discretion is provided, participants must make any such elections when they make their initial deferral elections. Participants may elect separate payment options for each of the triggering events. Effective with distributions made in 2007, NDCPs no longer may link the timing and/or form of their distributions to qualified plans.

So far so simple; however, a closer look at the details of the new rules reveals the layers of complexity that will require NDCP sponsors to proceed with caution:

- *No Room for Terrible Timing*—NDCP sponsors must ensure that distributions are only made upon triggering events unless they qualify as “permitted accelerations.” Permitted accelerations include payments for: domestic relations orders; divestitures from conflicts of interest; taxes on a violation of 409A; income tax withholding upon vesting in a 457(f) plan; Social Security (FICA) tax withholding and income tax thereon; and certain de minimis cash-outs. NDCP sponsors also now have the ability to terminate their plans under 409A upon the change of control of the sponsor, coincident with a liquidation of the sponsor, or at any time if the following three conditions are met: all similar NDCPs of the sponsor must be terminated with respect to all SPs; no payments may be made within 12 months of the termination; and no new similar NDCPs may be implemented within five years following the termination.

Participants may generally designate a year for distribution, rather than a specific date; doing so will result in a January 1 deemed distribution date. A payment will be treated as having been made on the designated date if it is made by the latest of the following dates: the first administratively feasible date after the designated date; the end of the calendar year containing the designated date; or two-and-a-half months after the designated date. Plans may be amended to provide for delays in payments under special circumstances, such as to ensure there will be no loss of the employer deduction for excess compensation. All NDCPs must impose a six-month delay of distributions to certain key employees made on account of separation from service if the company’s stock is publicly traded at the time of the distribution.

- *The Sinister Side of Subsequent Timing and/or Form Elections*—Although NDCP participants are given flexibility, the guidance could lead to administrative monstrosities. The regulations permit changes to participants’ original timing and form of payment elections, but only if a subsequent election is not effective until 12 months after it is made and provides for a payment date at least five years beyond the original scheduled payment date. If a payment is made pursuant to a specified time/fixed schedule distribution election, the subsequent election must be made at least 12 months before the first scheduled payment and deferred at least five years beyond the originally scheduled payment date. Subsequent elections for distributions due to death, disability, or an unforeseeable emergency cannot be effective until 12 months after the election and the five-year rule does not apply. However, the regulations clarify that a change in form of payment that results in a more rapid schedule for payments will *not* in itself constitute an impermissible acceleration. Thus, participants can switch from an original installment payment election to a lump-sum election if the subsequent election meets the 12-month and five-year requirements.
- *Installment Payments*—For purposes of applying the subsequent election rules, installments are generally treated as a single payment (occurring on the date of the first installment), unless the plan document provides for treating each individual installment as a separate payment. If a five-year installment payment is treated as a single payment and is scheduled to commence on January 1, 2007, then an SP could change the time

and form of the payment to a lump-sum on January 1, 2012, as long as the election is made before January 1, 2006. However, once the payment stream has begun, no changes are permitted. In contrast, if a five-year installment payment is designated in the document as five separate payments scheduled for the years 2007 through 2012, then the SP could elect a change to a lump sum either before or after payments have begun, provided that the new election does not take effect for 12 months and the lump sum is not paid until 2017 (five years after the last of the originally scheduled payments).

- *Life Annuities*—Life annuities must always be treated as a single payment. Thus, a life annuity commencing January 1, 2007, could be replaced with a lump-sum payment payable on January 1, 2012, without being considered an impermissible acceleration of some of the annuity payments. In addition, the regulations confirm that as long as the election is made before commencement of the benefit, participants may choose among actuarially equivalent life annuities *without* complying with either the 12-month or five-year rule.

The Dreaded Deadlines

Most, but not all, of the transition relief originally set to expire on December 31, 2005, is extended to December 31, 2006, including:

- *Documentary Compliance Amendments*—SRs must formally adopt 409A compliant plan documents for all arrangements subject to the new rules or else convert such plans into arrangements not subject to 409A by December 31, 2006.
- *Distribution Election Changes*—The period during which SRs may amend their plans' distribution options and SPs may change payment elections (whether as to timing or form) without resulting in an impermissible subsequent deferral or acceleration is generally extended through December 31, 2006.
- *Distributions Linked to Qualified Plan*—Although the 2005 relief provided for NDCP payments that are linked to payments from qualified plans is not made permanent, the rules provide relief for distributions made in 2006.

NDCP sponsors will need to take action before 2005 ends to qualify for:

- *Participant Deferral Cancellation*—If a participant wants to terminate plan participation or cancel deferral elections (in whole or in part) of amounts subject to 409A, the December 31, 2005, deadline still applies: the NDCP sponsor must adopt a plan amendment providing for such elections and distributions; the participant must make the election; and amounts received must be included in the participant's 2005 income. NDCP sponsors—especially those that previously permitted "haircut" withdrawals or other provisions that do not comply with 409A—may wish to consider offering this option because it will be the

participants' last chance to access their funds (while still employed) without facing the adverse 409A tax consequences.

- *Plan Termination*—NDCP sponsors wishing to terminate their pre-October 4, 2004, plans and immediately distribute benefits must do so by year's end or else become subject to 409A, which severely limits the circumstances under which such terminations can be effected.
- *Initial Elections by March 15, 2005*—Plans that operationally permitted participants to wait until March 15, 2005, to make their deferral elections for the 2005 calendar year under a special transition rule must be amended by December 31, 2005, to reflect such a provision.
- *Elections to Defer 2006 Salary*—All NDCP participants wishing to defer 2006 compensation (other than performance pay) must make their elections no later than December 31, 2005.
- *2006 Payment Election Changes*—Distribution election changes made in 2006 may neither postpone amounts originally scheduled to be paid in 2006 to a later year nor cause amounts originally scheduled to be paid in a later year to be accelerated into 2006. Accordingly, if any such changes are desired, the applicable plan amendment and participant election must be in place by December 31, 2005.

As this article was going to press, SRs received a last-minute reprieve from the IRS, which has waived the Form W-2 and Form 1099-MISC reporting requirements under 409A for the 2005 tax year.

The Moment of Truth for NDCP Sponsors

At first glance, 409A certainly presents a frightening façade for both SPs and SRs. Compliance failures will cause the deferred compensation to be subject to immediate taxation, with interest (calculated at a special higher rate) retroactive to the date it was deemed to have been deferred plus an excise tax of 20% of the amount now taxable. The good news is that when peeking behind the vicious veneer, one can envision a smoother transition to 409A compliance than was visible when the law and its initial guidance first emerged. But there are still plenty of tricks for the unprepared and the first real deadline is rapidly approaching. SRs should assemble an inventory of existing contracts and plans that might be on the 409A list and immediately enlist the aid of their own 409A-Team of benefits consultants, accountants, actuaries, and/or attorneys to develop and implement a compliance strategy.

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Making the Case for Wellness in the Workplace

by Alison Johnson, Michael Brovick, and Amanda Wobbema

Wellness. Employers and employees are all in favor of it.

But beyond the conceptual agreement, most have more questions than answers: How big a problem is wellness, or the lack of wellness? What is the financial impact of our lack of basic wellness? What are some effective ways to improve the level of wellness in the workplace?

What is Wellness?

Wellness is the practice of all the things that keep people healthy. It involves good nutrition, exercise, stress control, and positive personal and familial social relationships. Discussions of wellness typically focus on controllable risk factors that are closely associated with the development of diseases. For example, smoking and obesity are not diseases, but people with these risk factors are more likely to develop diseases such as lung cancer and diabetes, respectively.

Wellness programs focus on health risk factors than can be controlled with lifestyle modification.

When wellness is examined, one topic of some debate is the responsibility for wellness. While individual accountability for personal choice remains a starting point, others have significant interest in promoting the reduction of risk factors. Employers' workplace demands can expose a person to hazards, allergens, and stress; as a business, an employer benefits from higher levels of production and less absenteeism with healthy employees. Healthcare providers share in the responsibility for promoting healthy lifestyles. And societal pressures in general contribute to poor diet (e.g., "fast food" and oversized servings) and lack of exercise (e.g., city planning with an emphasis on the need for cars).

The Size of the Problem

A surprisingly large portion of Americans have at least one modifiable risk factor. There is no common and complete agreement of health risk factors, but Table 1 lists commonly measured aspects, based on data from the Centers for Disease Control and related sources.

A review of these prevalence numbers can leave the impression that nearly every American has at least one unhealthy risk factor. However, many, if not most, of these risk factors are related. For example, a person with obesity frequently does not engage in regular vigorous exercise. The interrelatedness of risk factors means that efforts to control one risk factor may also reduce other risk factors.

Financial Impact

Even though risk factors are not diseases, they are directly associated with higher healthcare costs. Smokers have more upper respiratory infections and obese people have much higher inci-

dences of diabetes and congestive heart failure. Figure 1 (on page 5) illustrates the overall cost of medical care for people with various risk factors. Every population with risk factors has average costs higher than the general population. Using \$100 in claims costs as a baseline, the figure shows that people who are more than 20% over ideal weight incur an additional \$37 in claims costs each year. Other risk factors show similar increased claims costs that range from an additional \$7 to \$35 per year. These claims costs reflect 1995 data and therefore would be higher today based upon inflation and healthcare cost increases.

Employer costs are even higher, taking into account health insurance premiums, lost work days, workers' compensation insurance, and disability. One 2001 study estimated the indirect cost of employee turnover, absenteeism, and nonoccupational disability to be \$5,000 per employee per year.

TABLE 1

PREVALENCE OF RISK FACTORS	
Risk Factor	% of Americans
Lack of regular, vigorous physical exercise	58%
Obesity	30%
High blood pressure	29%
Smoking	23%
Stress and mental disorders	22%
High cholesterol	18%
High alcohol use	7.7%
High blood glucose (diabetes)	6.6%

TABLE 2

COMPANIES' WELLNESS PROGRAM RESULTS	
Company	Reported Results from Wellness Programs
Motorola	For every \$1 invested, \$3.93 was saved.
DaimlerChrysler	Savings of up to \$16 per employee per month. Completion of a health risk assessment and participation in a wellness activity had average cost savings of \$200.35 per year per employee.
Union Pacific	A 10% decrease in healthcare costs in 2001 due to lifestyle-related factors, amounting to \$53.6 million in savings. Smoking dropped in prevalence from 40% to 28%.
Pfizer	Ergonomics program produced a return on investment of 3.51 to 1.
Johnson & Johnson	Medical care expenditures decreased by \$224.66 per employee per year over four years.

Benefits Perspectives

Current Issues in Employee Benefits

The Employer's Role

Is there an effective way for employers to promote employee wellness and reap the financial rewards of a healthier workforce?

Fortunately, yes. Health risk can be reduced and the reduction of risk factors results in less disease. The Harvard Center for Cancer Prevention estimates that the adoption of healthy lifestyles could prevent over 80% of heart disease, 70% of strokes, and 50% of cancers. And other studies have shown that wellness and disease management programs offered by employers have helped to decrease costs. Some companies' results are reflected in Table 2 (on page 4).

Five Good Ideas

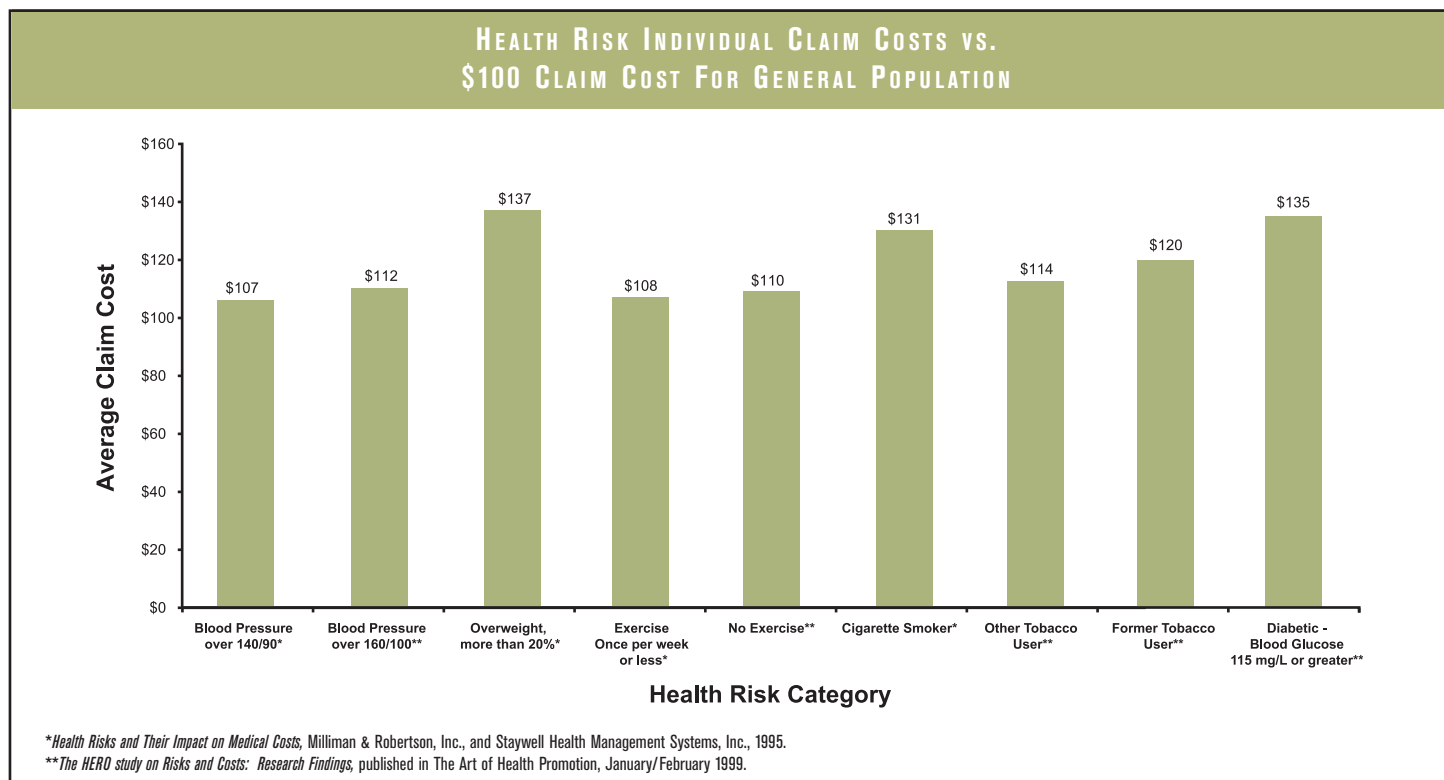
The following are some ideas for employers contemplating steps to improve the level of wellness in the workplace:

- *Decide whether to "make" or to "buy"*—Should you pay a company that specializes in wellness to manage your employees or should you develop a program internally? Is there an inexpensive way to ease into wellness programs? To help with this difficult decision, an employer could issue a request for proposal and evaluate responses. The development of an internal program also should be considered as one of the responses to such a proposal.
- *Pay attention to enrollment*—Successful programs induce people to participate and participation must result in the reduction of risk factors. A successful smoking cessation program will sign up many people and

some will actually quit smoking. The first critical step is enrollment. The overall participation rate in a wellness program is about 10% when information is mailed, but can be boosted to 30% with more aggressive approaches such as worksite notification and calling campaigns.

- *Offer incentives*—A tangible reward to change employee behavior can be the final inspiration a person needs to form a new habit. A variety of innovative ideas have been tried, ranging from expensive cash rewards, merchandise, and vacations, to simpler acknowledgements of success and achievement. Incentives must focus closely on what the employees find motivating (see sidebar on page 6).
- *Provide coaching or mentoring*—Employers have found coaching or mentoring individuals an effective approach to encourage new health behaviors. The health coach/mentor and the employee have periodic (usually weekly) telephone appointments to discuss behavior changes. Together they verbally agree on small, incremental steps that will move the employee toward his or her goal, such as walking for 15 minutes three days after work, or counting the number of cigarettes smoked and recording the times each day. The health coach/mentor assesses the employee's readiness for change, and provides information, encouragement, and specific suggestions based on a prescribed course for the individual. Coaching and mentoring, when included, are typically the most expensive part of wellness programs but have produced significantly higher compliance rates with smoking cessation and diet modification programs.

FIGURE 1



- *Practice patience*—Employers need to consider the length of time required for people to change their behavior, reduce their risk factors, and produce healthcare cost reductions. Wellness program participation rates and behavioral change can certainly be measured in a year, but evaluating the effects on risk factors or healthcare costs will likely take longer.

Conclusion

As risk factors—particularly obesity and its related effects—increase, employers, employees, healthcare providers, and public officials are turning to wellness programs with renewed interest. Properly designed and implemented, wellness programs have the ability to reduce risk factors and boost overall health in the employer group health setting.

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Employee Incentives

Cash	Cash payments for completion of a wellness program or the achievement of specific goals can range from several hundred dollars as a lump sum to smaller amounts for incremental steps.
Healthcare Costs Payments	Reduction in costs might target health insurance premiums, deductibles, or employee co-pays, or could provide coverage for items not normally covered, such as smoking cessation medications.
Gifts	Points may be awarded for various activities (keeping appointments, getting lab work completed, losing weight, exercising), redeemable for merchandise through a catalog or website.
Health Promotion Items	Pedometers, water bottles, health journals, health club membership, weight loss program fees, and exercise and fitness sessions with trainers could be given to employees.
Recognition	Certificates and awards to mark milestones, time off, casual dress days, and special parking spots may be offered.

Evidence-Based Medicine: What Employers Need to Know

by Sherrie Dulworth

The term “evidence-based medicine” has spread through the medical vocabulary in the past decade. A search on the Internet for the phrase returns more than a staggering 2 million pages. Has its ubiquitous use merely created a generic, industry catch phrase? Is all medical protocol “evidence-based?” And what is the importance and applicability of evidence-based medicine for employers and their employees?

Brief History Highlights

In the not too distant past, medical practice was based upon a combination of folklore and knowledge passed down through generations. Opinion of treatments that worked and those that did not was largely conjecture based upon an individual practitioner’s and his or her patient’s observations, sometimes combined with a scientific basis for conclusions.

Sometimes they were right. In 1840 a Viennese physician, Ignaz Semmelweiss, concluded there was a relationship between hand washing and sepsis-related mortality rates on the post-partum wards. His colleagues resisted this idea because microscopic organisms could not be seen at that time. Semmelweiss was professionally ostracized and was not vindicated until after his death. Louis Pasteur later proved that germs cause infection.

Sometimes they were wrong. Bloodletting was a popular practice during the 18th and 19th centuries. Doctors routinely bled patients for vari-

ous conditions including pneumonia, fever, back pain, and headaches. In 1799, President George Washington died after developing a throat infection and then being “treated” by excessive blood letting (one report estimates almost four liters were removed in about 10 hours). This quite likely contributed to his demise.

Fast forward. In the late 1980s and early 1990s, there was movement on multiple fronts toward the current state of evidence-based medicine. In 1989, the US Preventative Services Task Force convened to evaluate research and issue guidelines for preventive interventions. In the early 1990s, the predecessor organization to the Agency for Healthcare Research and Quality (AHRQ) began creating evidence-based guidelines. It later discontinued this effort but established Evidence-Based Practice Centers to produce reports and assessments. In the mid-1990s, London Professor David Sackett’s work helped to establish how treatments can be measured, how clinical trials (i.e., the testing of a drug or treatment on patients) should be run, and how to improve treatments for the benefit of patients. During this time period, Dr. John Wennberg, of the Dartmouth Center for the Evaluative Clinical Sciences, documented his seminal work on the practice of medical care that cannot be explained on the basis of illness, medical evidence, or patient preferences (i.e. healthcare variation).

Benefits Perspectives

Current Issues in Employee Benefits

What is Evidence-Based Medicine?

The Oxford Centre for Evidence Based Medicine (CEBM) defines the term as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients,” and “integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

Thus, the current recommended practice for treating low back pain with early mobilization and lumbar strengthening exercises, rather than the previous treatment of several weeks of bed rest, is an example of applying evidence-based medicine.

Furthermore, evidence-based medical principles extend to evidence-based healthcare, including the purchasing and management components. A healthcare network steering members having a coronary artery bypass graft to a high volume facility, which research shows leads to reduced mortality, is an example of evidence-based healthcare.

All Evidence Is Not Created Equal

In theory, evidence-based medicine is a popular concept with few opponents or detractors. In an ideal world, all medical practice would be based upon credible scientific research, be easily interpreted, have clear results, and be accessible for all conditions. But the reality suggests otherwise.

The gold standard of evidence-based medicine is the randomized, controlled trial (RCT) study. At the top of the scale of rankings for evidence-based medicine, the RCT—which ranks “Evidence Grade 1” (see sidebar)—is a clinical trial or scientific procedure to test the effectiveness of medicines or medical

procedures; it is the best known design for eliminating the various biases that regularly compromise the validity of medical research.

But there is a limited amount of evidence based upon RCTs, much of which is related to pharmaceutical treatments. RCTs are costly and often lengthy by nature. Fortunately, other types of evidence beyond the RCT are valid and valuable in the evaluation of medical practice. Much of today’s current practice, including many national quality initiatives, is based upon “Evidence Grade” level 2. Sometimes the available evidence is inconclusive or contradictory.

The evidence must be viewed in light of the specific characteristics and applicability for each patient. But even when there is solid evidence, it should not be applied in a cookie-cutter fashion; clinical interpretation and the evaluation of the evidence is necessary to determine if it is pertinent to the particular case or if a specific patient is an exception to what the evidence might suggest.

One area that is lacking in much of the medical literature is the impact on physical functional ability and quality of life outcomes with various treatment options. This is especially pertinent when trying to evaluate the merits of surgery over conservative or noninvasive medical treatment for elective conditions. Future research in this important area is expected to provide more relevant information.

Employer Initiatives

As purchasers of healthcare services, employers are positioned to play an important role in evidence-based healthcare. For example, three key activities they might focus on are:

Know what standard is being used to manage your employees—Ideally, treatment and review guidelines are created using solid evidence-based medicine. Most health plans and medical management organizations use guidelines in their utilization management, care management, and disease management processes. Some organizations develop their own criteria, while others access publicly available criteria, and the majority purchase externally developed criteria.

As part of their performance evaluation of those organizations, employers should inquire about the clinical criteria that are used. Some questions to ask are:

- *How are the clinical guidelines developed and how rigorously are they supported by evidence-based medicine?* How thoroughly is the medical literature reviewed? What is the number of articles reviewed and what are their citations? How is the evidence graded? How are conflicting studies evaluated? Are they derived from clinically credible sources?

A descriptive summary of the three levels used to develop the *Milliman Care Guidelines*®, (in order of importance) is shown below. These levels are based upon a generally accepted hierarchy used in weighing or grading the evidence found in the Oxford CEBM levels.

MILLIMAN CARE GUIDELINES— INPATIENT AND SURGICAL CARE—EVIDENCE GRADES		
(EG 1) Evidence Grade 1: Randomized controlled trials	(EG 2) Evidence Grade 2: Other published sources	(EG 3) Evidence Grade 3: Unpublished data
Meta-analysis with original patient data	Series with historical controls reports from large practices	Written protocols or outcomes
Randomized controlled trials with meta-analysis	Case control series	Large database analysis
Simple randomized control trials	Case series with literature controls	Expert practitioner reports
Systematic reviews	Published guidelines from literature analysis (non meta-analysis)	
	Published guidelines from consensus processes of national organizations	
	Published guidelines from consensus processes	
	Uncontrolled case series	
	Statements in published articles or textbooks	
	Case reports	

- *What are the qualifications of those who develop the clinical guidelines?* The accurate interpretation of the methodology and outcomes from the medical literature is critical to guideline development. This requires having a depth and breadth of qualified personnel dedicated to ongoing research and development.
- *How often are the guidelines updated?* A familiar example of a change in medical practice due to updated evidence is the evaluation of a patient with peptic ulcer disease for a bacterial infection (with *Helicobacter pylori*) rather than simply attributing the symptoms to diet and stress. There is a rapid explosion in some areas of medical evidence, especially biotechnologies and imaging. Without frequent literature review and updates, out-dated evidence guidelines will be used.
- *How functional is the evidence that is presented?* Many guidelines are constructed in a way that is academically sound but that lack practical application in a real world environment. Guidelines should be adaptable and functional.

Demand excellence—Measure your health plan’s performance in relation to its adherence to evidence-based medical criteria. The National Committee for Quality Assurance’s (NCQA) Health Plan Employer Data and Information Set (HEDIS) measures contain guidelines for the treatment and evaluation of specific conditions and help evaluate the effectiveness of care. The *Bridges to Excellence* pay-for-performance program with employer and physician participants (with NCQA administration) is an example of rewarding high performance based upon evidence-based medicine.

Evaluate your network provider performance against some of the leading evidence-based performance measures, such as: the Centers for Medicare and Medicaid Services’ (CMS) Hospital Quality Initiative (for heart failure, myocardial infarction, and pneumonia); the Leapfrog Group for Patient Safety’s recommended safety and quality practices; or the National Quality Forum’s National Voluntary Consensus Standards for Hospital Care.

Develop benefit choices that support evidence-based best practices—The National Committee on Evidence-Based Benefit Design is an initiative of the National Business Group on Health (NBGH). Its mission is to improve quality of care and promote value by using benefit plan design to encourage and reward effective care, while discouraging ineffective care. By linking benefit design to medical practices with demonstrated effectiveness, the Committee seeks to enhance the health and quality of life of employees and their dependents and improve employers’ return on benefits investment.

Among the resources offered by NBGH are benefit design tools for back surgery in adults, cervical cancer screening, and hypertension. For example, the NBGH’s information on the differences in coverage approaches for back surgery provides data for selected procedures between employers that want to take a more aggressive benefit design approach and those that choose to be less aggressive; for hypertension, information includes pharmacy plan edits to improve hypertension care. The NBGH also has useful tools to help employers communicate with their employees.

Conclusion

By facilitating the application of evidence-based healthcare, employers can become part of a positive momentum: the use of evidence that is based upon rigorous standards and scrutiny promotes better decision-making. Better decision-making can, in turn, lead to better outcomes. Better outcomes can result in healthier and more productive employees—evidence of why “the evidence” is important to employers and everyone concerned.

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