

Quarterly Review

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From the Desk of the Editor

The quest for the health care Holy Grail and with it the balance between cost, quality and access continues. Since the State of the Union Address, proponents and critics of the Bush Proposal on both sides of the aisle as well as various special interest groups have been squaring off and using the air waves and print to explain their solutions and promote their positions. States continue to go their own way with many watching the big trend-setters: Massachusetts, and California, as well as a recent entrant with a completely different approach - the State of Tennessee. With the latter you are likely to hear a whole lot more about Mini-meds (limited medical plans). In case you are not familiar, Bob Dunn has written a short article on these plans at page 5.

Whether you see healthcare reform as a threat or promise, it's hard to remain neutral and dangerous to be uninformed; for many industry veterans, it's déjà vous. A new contributor Giny Sampson has been following the trends and provided a snippet of the early research. As I began pulling together this newsletter I was reminded of a Letter to the Editor Mike Sheridan wrote in 1992. Mike's 10 steps to health care reform are as relevant today as they were 15 years ago - I have reproduced his Letter to the Editor in this issue (page 7).

We met recently with a friend and partner just returning from a White House briefing on health care. It appears the headlines pronouncing certain death to tax-favored accounts were greatly exaggerated. And hopefully, employer-provided health care is in less jeopardy than reported as well. This was welcome validation of our own forecasts. Recently in my readings I came across a quote loosely attributed to Churchill which made me pause, reflect, and then chuckle: **Employer-based insurance is the worst option for providing health insurance except for all of the others.**

On the regulatory front it's been fairly quiet; however, the deadline to begin using the national provider identifier (NPI) is May 23rd, and complying with GASB 43 and 45 should be an active and ongoing process if you are a public employer. Regarding the latter, we have been working with several public employers on post-employment strategies and as our Featured Article we are including a detailed info article about GASB in general as well as our approach for your interest and consideration.

Enjoy, Trish

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FBMC Partner Visits Whitehouse

More on Healthcare Reform
Trish Neely, CFCI

Last month, FBMC technology partner Vishal Sibal, President of SANARE, was invited to attend a meeting at the White House to discuss the Bush Proposal on Healthcare, as well as the future for HSAs. We met with Mr. Sibal to discuss his perspectives from the meeting and I am providing some of the highlights from our discussion below. My interjections are in italics.

As you may recall, at the heart of the president's proposal was a repeal of tax exclusions for employer-provided health insurance, including HRAs and MFSAs. The rationale being to "level the playing field" between Americans who receive their healthcare through their employer vs. those who purchase through the individual insurance market, hopefully resulting in greater access to coverages and fewer uninsured. HSAs were specifically excluded from the tax repeal and thus not impacted by the proposal.

As reported by Mr. Sibal, during the meeting, an assistant to the President on Economic Policy spoke in support of the President's overall Healthcare proposal stating that it would result in tremendous strengthening of the individual market; and contrary to some critics, was not intended to destroy the group market. However, he acknowledged the uphill battle ahead.

Equally important, the president's proposal would provide existing federal healthcare funds to help states expand existing programs or create new ones. As reported by Mr. Sibal, a healthcare advisor to Charlie Rangel (D-NY) stated the Ds are watching the

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Massachusetts and California models and stated we may see some type of safety net with the states as part of the D's platform. (As an aside, the April 18th issue of the Wall Street Journal had front page coverage for Tennessee Gov. Phil Bredesen's (D) mini-medical approach to the healthcare crisis in his state.) The advisor also mentioned national health care and the need for Fortune 500 companies to push this agenda. This may be a preview of upcoming campaign and convention dialogue.

Mr. Sibal's White House visit was primarily to assess the short and long-term viability of Health Savings Accounts (HSAs). A number of FBMC clients have or are considering Health Savings Accounts as part of long-term strategies to address spiraling health premiums and costs. In that regard, an assistant to Senator Orrin Hatch (R-UT), offered that Republicans realize the next two years will not be a hospitable environment for HSA expansion; however, the Rs will wage war if the accounts are threatened. A Democratic advisor countered that Ds will not kill HSAs – but neither will they support or enhance them further – what passed last year (in the way of HSA clarifications and enhancements) would not pass this year. (We are hopeful the change in climate has minimal impact on the anticipated Grab Bag of guidance on HSAs expected soon from Treasury.)

Mr. Sibal reported that an attorney from the Office of Tax Policy, Treasury was on hand to review recent Treasury guidance and appeared to state for the record that HSA substantiation is never going to happen. HSA's are and will remain self-certifying by participants. An official from the DOL confirmed his agency does not consider an HSA plan to be an ERISA covered plan as long as there is choice among custodians.

Mr. Sibal's feedback is consistent with industry feedback and speculation and conferences we have attended with policy makers present; however, more validation is always comforting.

In a report, released 3/20/07 (subsequent to the White House visit), the Joint Committee on Taxation (JCT) estimates that the president's plan would increase taxes by \$333.6 billion over an 8-yr period. House Ways and Means Health Subcommittee Chairman Fortney Pete Stark (D-CA) requested an analysis of the proposal by the JCT. The report stated that upon initial implementation in 2009, more taxpayers would experience a **decrease** in tax liability; however, by 2017 more taxpayers would see an **increase** in taxes that would affect all taxpayers with incomes above \$40K/yr. On a positive note, by 2017 about 8 million fewer people would be uninsured. See www.cbo.gov/ftpdocs/78xx/doc7877/03-21-presidentsbudget.pdf for the complete report.

Featured Article

GASB - Are You Ready?

Patrick Peters
Fred Anderson, CPA

What is the Challenge?

The Government Accounting Standards Board (GASB), a national accounting standards board, establishes financial and reporting standards for state and local governments. In June 2004, GASB issued statement No. 45, an accounting and reporting standard to improve financial transparency for the cost of Other Post Employment Benefits (OPEB). The statement requires public employers to report the cost and long-term obligations related to benefits they provide for retirees in addition to pensions.

If an employer does not offer OPEB in any form, then GASB compliance would reflect no additional OPEB liability on the financials. However many states, including Florida, by state statute, allow retirees to continue participation in the employers' health plan at a premium rate no greater than that of active employees. This provision creates an implicit liability that can be substantial. (See GASB liability chart, page 13)

When is GASB Effective?

Compliance Phase	Revenue Based on fiscal 1998/1999	<u>Statement No. 43</u> For Fiscal Year Beginning After	<u>Statement No. 45</u> For Fiscal Year Beginning After
1	Greater than \$100 Million	December 15 th 2005	December 15 th 2006
2	Between \$10 and \$100 Million	December 15 th 2006	December 15 th 2007
3	Under \$10 Million	December 15 th 2007	December 15 th 2008

What is the Impact on Financial Statements?

Prior to GASB 45, state and local governments typically followed a "pay-as-you-go" accounting (see Pay as You Go chart on page 12) for OPEB on their financial statements including their Comprehensive Annual Financial Reports (CAFR). The costs of retirees' benefits were only reported when employees retired. GASB 45 requires employers to quantify and disclose their OPEB liabilities in their financial statements and footnotes. This new standard makes obsolete the current pay-as-you-go accounting for OPEB. It aligns

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public accounting standards more closely with that of the private sector standards which were adopted in the mid 1990's.

GASB 45 Requirements:

In order to comply with GASB 45, public employers must have an actuarial valuation of their OPEB performed. The valuation will determine:

1. the employer's annual required contribution (ARC),
2. the unfunded actuarial accrued liability (UAAL),
3. the actuarial value of assets use to fund the plan, based on future and current values

Standards for Certifiable Valuations include:

1. Must be performed every two to three years by a certified actuary
2. Actuarial assumptions must conform to standards of actuarial practice;
3. The maximum amortization period allowed is 30 years;
4. Valuation certification must include a prudent investment strategy which demonstrates a projection of a reasonable long term return on investment (ROI);
5. The actuarial value of assets must be based on a market related model.

Issues Resulting from Non-Compliance

Some entities are protesting GASB and are considering a move away from GASB standards in favor of the Financial Accounting Standards Board (FASB) – the corresponding board that establishes and improves standards of financial accounting and reporting for the private sector. This may not be a viable approach as FASB implemented similar requirements in the mid 1990's. Any deviations from the GASB standards will be noted on an employer's financial statements and could have an impact on whether an auditor would issue a fairness opinion.

At a minimum, employers should have an Actuarial Analysis of their OPEB liability to determine the magnitude of the actuarial accrued liability, the annual required contribution (ARC) and the actuarial value of the assets. Although there is no requirement to fund OPEB or the actuarial accrued liability, the accumulated deficiency will be reflected as an unfunded actuarial accrued liability (UAAL) on the financial statements.

Impact on Bond Rating

- "Liability is not new, but GASB 45 will provide meaningful new information about the current and future cost of these benefits and require more complete disclosure". (Standard & Poor's, 2006)
- "The costs associated with retiree health benefits, though they have been magnified by growth in healthcare spending, are not a new phenomenon. Governments in the coming years will have to improve their measurement and disclose OPEB cost and liabilities under statements 43 and 45 of

the government Accounting Standards Board (GASB)". (Moody's Investors Service, 2005)

- "Fitch Ratings views GASB 45 as a positive step toward more fully illuminating governmental obligations to retirees, but acknowledges the inherent tension between allocating scarce resources toward critical government services today and meeting the funding requirements for retirement benefits that might not be due for decades. Fitch anticipates that governments will thoroughly review retiree benefit programs; responses to OPEB funding challenges will vary considerably. However, Fitch expects many governments will approach GASB 45 in much the same way they responded to the adoption of pension system actuarial and accounting standards, by steadily ramping up annual contributions to actuarially determined levels, altering benefit plans, or taking other actions to ensure long-term plan solvency" (Fitch Ratings, 2005).

The perception of the entity's inability to service debt would severely curb their borrowing power.

Steps to Compliance

- Examine and assess all employer agreements, commitments and collective bargaining agreements related to post employment benefits to determine where exposure exists.
- Open the channels of discussion with employees, retirees, collective bargaining groups and other stakeholders to ensure the entity's ability to provide a sustainable retirement benefit package into the foreseeable future.
- Consider reduction or elimination of retiree benefits other than pensions. This will require skilled negotiation with impacted stakeholders as organizations are not willing to give up retiree benefits without a fight
- Establish an irrevocable Trust. There are a variety of trusts available including IRC §501(c)(9) Voluntary Employee Benefit Association ("VEBA") trusts, Internal Revenue code ("IRC") §401(h) trusts and IRC §115 trusts. There are several advantages and disadvantages to each of these trusts. Choose the one that best fits your circumstance.
- Pre-fund the trust as much as possible before the GASB requirement takes affect. This will have the affect of reducing the UAAL and the ARC in the actuarial analysis.
- Allocate funding to a GASB qualified trust to pre-fund and actuarially fund the ARC.

SOLUTION TO THE GASB OPEB DILEMMA

Although OPEB is fundamentally a "cashflow issue", a comprehensive solution **must** go beyond accounting and financial perspectives and identify avenues that

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would reduce the OPEB liability itself. We offer one such solution in the form of a **Retiree HRA**.

Our **Retiree HRA** solution, compliant with GASB 43 and 45, allows employers the ability to reduce the liability by providing a completely flexible plan structure and a plan that is portable – a plan that would be an enhancement to the current retiree benefit commitments. Plan Features:

- In the most general description, the Retiree HRA is a VEBA;
- It is a GASB compliant Trust, in the employers name as grantor and for their employees as beneficiaries, that funds Health Reimbursement Arrangements (HRA) and retains the tax advantages of both vehicles.
- It's assets are held by Wilmington Trust – a century old trust company with over \$42 billion in assets whose reputation is of the highest quality.
- An HRA, from VEBA held investments, funds the premiums for retirees covered under employer's retiree health plan. FBMC acts as the HRA administrator for premium billing and collection, customer service and claims.
- The HRA can, if desired, fund premiums for retirees who are not covered under the employer's retiree health plan.
- The HRA can fund premiums for retirees' long term care plan and long term disability plans
- The HRA can pay for out of pocket expenses associated with all qualified medical expenses under §213(d).

The benefits of this approach include stability and predictability of retiree health benefits - reduced liability because a retiree HRA is not a defined benefit plan and is not subject to GASB 45.

If you would like to learn more about the FBMC approach, please contact the undersigned at ppeters@fbmc-benefits.com. With over 30 years experience in the public sector market, FBMC understands the nature of public employer benefits and collective bargaining agreements. We are the recognized leader in the administration of employee benefit services to State Governments, Public Schools, City, County and other municipalities.

In The News

NPI Implementation Deadline Approaches

Trish Neely, CFCI
Michael Ryan of 21st Century contributed to this article

Covered health providers must be in compliance with the National Provider Identifier (NPI) Rule by 5/23/2007; small health plans (annual gross receipts less than

\$5Mill) have an additional year to comply - 5/23/2008. The NPI Rule is another of HIPAA's Administrative Simplification mandates. The purpose of this requirement is to improve and ease communication between providers who exchange covered health information, electronically. With the current practice of payors assigning numbers to providers to distinguish claims payments, a provider may have hundreds of different identifiers. This made claims payment and coordination of benefits challenging to say the least.

Only health care providers are eligible to apply for and obtain an NPI; only those providers that exchange information electronically **must** obtain one.

If you as a plan sponsor would like to begin using a unique identifier, according to the agency, you will use your 10-digit EIN.

What does being in compliance mean; and who does the rule apply to?

Compliance means that the NPI is used to identify the health providers on all EDI transactions. The covered health provider may be a physician, dentist, physician group, hospital or nursing home that exchanges health information with its various health care partners. Health care partners may include Medicare, clearinghouses, billing entities, other health providers, health plans, and claims payers.

What happens if a covered entity is not in compliance?

CMS has the authority to enforce all non-privacy provisions of HIPAA, including enforcement of NPI implementation. CMS will focus on voluntary compliance and the agency will consider good faith efforts to comply when assessing complaints against a covered entity. CMS recognizes that under §1176(b) of the Social Security Act, HHS may **not** impose a civil monetary penalty where the failure to comply is based on reasonable cause and not willful neglect. HHS will continue to provide technical assistance to the industry while the transition occurs. From a recent teleconference, we learned that HHS has received a number of inquiries expressing concern about the health care industry's ability to comply by the May deadline.

FBMC is making the necessary modifications to store either the health care provider or client identifier on HIPAA covered transactions that we receive electronically.

Plan Sponsors, Benefit Administrators, and TPAs (third party administrators) are not considered covered entities; it is the group health plan itself that that must be compliant. As a result there continues to be debate

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in the industry and amongst employers as to when and how they must comply with any of HIPAA's privacy and security provisions. As a result of feedback received to date, we do not anticipate many of our Clients who contract with FBMC for tax-favored account services only, or the providers associated with those benefit plans to begin using the EIN or NPI identifiers. Nevertheless, we are readying our tax-favored account platforms to be able to accept the identifiers if provided.

On the other hand, we do anticipate our Clients who contract with FBMC and our wholly-owned subsidiary 21st Century for self-insured benefits, and the health providers associated with those benefit plans to begin using the unique identifiers on some if not all electronic files. We recognize that some clients or providers may not elect to do so, or may not be ready May 23rd; however, we are readying our systems to be compliant in early May and will initially use a cross-referencing approach to track NPI and/or existing identifiers. Based upon guidance from the agency, for the short term at least, covered entities need to make a good faith attempt to comply with the standards.

HIMMS Survey puts compliance at 40%

According to a January 2007 survey by the Healthcare Information and Management Systems Society of 105 health IT professionals, 40% said they have an NPI, are testing it with their payers and vendors and expect their billing and practice management systems to be ready for the May deadline; 28% were not ready; and 32% didn't know. Only 10% of those surveyed said they were already using their NPI in electronic transactions.

Health Care Trends Emerging

Gingy Sampson, Benefits Analyst

In early February, FBMC formed a task force to monitor industry, state and federal activity related to health care reform. As a member of that task force my initial assignment was to begin collecting and analyzing various reform strategies at the state level with an eye on identifying and monitoring trends. Although my research is still in its infancy, we though you might be interested in a sampling of the trends that are starting to emerge. The requirement of individual responsibility to purchase insurance coupled with employer responsibility to finance insurance (first two bullets) appears to us an appealing strategy from a political standpoint. If you would like to discuss further or have information to share, please contact the undersigned at gsampson@fbmc-benefits.com.

- Legislation to require all state residents to have health insurance (just as residents are currently required to carry auto insurance). California and Massachusetts include in their initiatives.

- State fair share bills that require businesses of a certain size to fund health insurance or pay into a state fund to provide insurance. Examples include California, Maryland, Massachusetts and Vermont.
- Tax deductions or credits to help individuals purchase health insurance (Bush Proposal included)
- Expanding Medicare/Medicaid to include the uninsurable or those without coverage through the workplace
- Providing state-paid universal health care coverage to children
- Requiring insurers/underwriters to extend affordable coverage in a non-discriminatory manner (i.e. same rate regardless of age, gender, occupation, health condition)
- Realization that one size does not fit all. Looking at more affordable limited insurance products in addition to comprehensive insurance (Tennessee model)
- Discounts for health and productivity programs (disease management and wellness programs) or for individuals who use preventive care and maintain healthy lifestyles.

Editors note: States must be cautious when putting together their initiatives or risk running afoul of ERISA. In the July 2006 edition of this newsletter we reported that a U.S. District Judge struck down Maryland's Health Care Act finding that the law was preempted by ERISA.

Mini-Med Plans

Old solution – New Strategy?

Robert Dunn, CLU

You can call them limited medical, mini-medical, or mini-med plans. Tennessee Governor Phil Bredesen calls it the **CoverTN** program approved last year by the state legislature (enrollment began 3/2007). A recent WSJ article (4/18/2007) describing the financial circumstances that led this first term governor to cut 170,000 adults from the State's TennCare (Medicaid) program and to invite focus groups to craft the new CoverTN program provided yet another example of a State striking out with its own strategy rather than waiting for Washington.

Mini-med plans are not new – fast food restaurants, employers who hire seasonal or part-timers are familiar with these plans. You can be sure eyes will be watching the State of Tennessee where a mini-med plan is in place to provide access to emergency room, doctors' offices and RX to the uninsured without requiring significant upfront deductibles to be paid, without draining slim pocketbooks on premium payments, without draining state coffers, or placing undo burden on businesses. In responding to critics' jibes that it's "flimsy insurance" or that it does not

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address catastrophic illnesses, the Governor responds that many people in his state simply cannot afford and don't want comprehensive coverage. As to some of the more ambitious plans his peers are advocating, he questions whether their states will be able to fund them.

Mini-Meds vs. Supplemental Plans. While Mini-meds and supplemental plans may serve the same markets, coverage differs considerably. Mini-meds are typically designed for part-time employees, seasonal employees or those employees who are not yet eligible for their employers' group health plans – thus the Mini-med is the health plan.

Supplemental medical plans also known as GAP plans, hospital income and/or critical illness insurance are typically offered to employees with high deductible health plans, Medicare, and as the name implies, supplement an existing health plan.

There are two types of plans that classify as mini-med coverage – indemnity and co-pay/coinsurance. Indemnity plans pay the provider a fixed rate for medical services including doctor visits, hospital stays, prescription drugs, etc. Members are responsible for the difference between the fixed rate and the actual charge. Co-pay plans pay a percentage of a network discount price or usual customary charges incurred. Members are responsible for any charges in excess of the benefit maximums.

Mini-med products are difficult to compare apples to apples with most carriers offering a number of set or standardized plans, as well as customized plans within certain parameters. Plan rates are based on gender, turnover rate and geographic location with shelf rates available for standardized plans.

There are some important characteristics to consider among the various products, including pre-existing condition limitations and pooled benefit caps.

Pre-existing Condition Limitations. Some plans include pre-existing condition language. Two immediate problems arise whenever this limitation exists. First employees with chronic conditions will expect their treatment to be covered, only to find it is not because they have been treated for it in the past. Second claims will not be paid as quickly because the carrier must ascertain whether or not the claim is for a pre-existing condition. Both of these items should be a concern for groups with high turnover. Pre-existing condition limitations must be fully explained to the employee and employer in enrollment and marketing brochures.

Pooled Benefit Caps. Plans can be structured so that all or some benefits are paid from a pooled annual benefit limitation. These plans contain a common fund for all outpatient benefits so that regardless of the

annual limits for each type of benefit, once the overall outpatient payments reach the limit ('draining the pool') all outpatient benefits cease for the year even though benefit limits have not been reached.

The key to successfully installing a mini-med plan is to provide detailed explanation of the plan selected; disclosure is the watchword. In the case of CoverTN, the administrator stamped "limited benefits" in bright red on the insurance cards and each EOB sent to a member provides an accounting of benefits used and shows how close he/she is to reaching the benefit limit.

If you are interested in receiving more information including a comparison of four plans offered by leading underwriters of this type of product, please contact the undersigned at bdunn@fbmc-benefits.com.

A Perspective from the Hill

Robert McKnight, Senator

As is apparent to most of us following activities on the Hill, we have a partial "lull" in congressional or administration activity related to our benefits industry. Although we have been monitoring several Congressional proposals to take ERs out of the business of providing health care, most of the Washington focus as of this writing is on the Easter/Passover recess, funding for the war in Iraq, Democratic Party subpoenas, and the presidential campaign. Speaking of the presidential campaign, now that the polls are being released each week, all but the front runners are disclaiming the polls as irrelevant. Although their assertions are an attempt to blunt the polls' effect on their campaigns, those candidates are probably right, but for different reasons (in the opinion of this author). From experience, the reasons the polls are subject to change (in some cases dramatic) are the following possibilities:

1. Polling is typically done by state. However, in the final general election, the weighted electoral college is used which multiplies the assigned votes to the states, based upon population. So in a poll, South Dakota could represent the same number of voters as California, but the actual outcome could be quite different. To be clear, the candidates are very aware of the difference, as you will notice from their last minute campaign schedules.
2. The selection of the presidential candidate's running mate can make a big difference in the final outcome, but that selection is usually not announced until the end of the campaign. Most observers feel that President Kennedy's selection of then Sen. Lyndon Johnson sealed their victory

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because of Johnson's strong support in the South and his political power as reigning head of the U.S. Senate. Many candidates try to balance their identity by geography, gender, age, race, and issue identity. In some cases, the selection has been either a killer or winner for the presidential candidate.

3. The actual voter turnout can often be different than those represented by the polls. It is well established today that the percentage of voter turnout for women, senior citizens, race (often turning out in greater numbers if the ticket includes a similar racial makeup), geography, religion, and even weather. Interestingly, probably the most generous financial supporters of political campaigns—white businesspeople and professionals, register the smallest turnout and percentage of turnout. Over the years, as a result of this dynamic, campaign professionals have devised some very creative and sometimes border line legality strategies, to "get out" the candidates' base vote.
4. Last minute "gaffe" syndrome often derails front runners in presidential elections. In the very beginning of most campaigns an extraordinary amount of time is spent reviewing the candidate's potential "skeletons in the closet," to avoid this syndrome. These problems can be so central to a campaign, that the timing of their disclosure and the medium by which they are disclosed (i.e., the press or third parties), is often considered critical. Many of us remember the historic gaffe of presidential front runner, Michigan Governor George Romney, approximately 40 years ago. Probably the most used disclosure is if an opponent has either failed to vote as an elector or in a previous office—often referred to as the "empty chair" award. It is taken the toll of many a losing candidate in elections at every level.

So, as we prepare for the advent of the election cycle, and monitor the candidate's position of issues affecting our benefits industry, let's not get too excited about the polls—if history is any lesson, the final votes may be different. Just ask the political affair students of the Truman-Dewey presidential campaign in this country.

Letter to the Editor Changes Needed Now in Nation's Health Care

Mike Sheridan, Chairman FBMC

Editor's note: This timely article is reprinted from a May 11, 1992 article in the Tallahassee Democrat by Michael Sheridan, then President of Fringe Benefits Management Company.

The health-care crisis is wrongly focused on insurance. The real problem is how to provide access to health

care for all of our citizens. How to pay for it—taxes, insurances, etc. is the secondary issue.

If one believes that access to health care should be a basic right in as advanced society such as ours, then the following steps could be considered:

- Establish national, not different state-by-state, standards for preventive as well as remedial health care.
- Require all employers, including self-employed, to provide and pay for no less than a nationally standardized health plan for each employee, underwritten by insurance companies.
- Expand the use of out-patient facilities for the treatment of most non-surgical, non-complicated illnesses or injuries.
- Require all hospitals, doctors, etc., to deliver health care to anyone regardless of their ownership of health insurance.
- Impose a national resource-based, relative-value scale billing system on all health-care providers.
- Allow health-care providers to bill a single source payor for uninsured patients. Fund this program from two sources;
 - One, an equalization assessment on health care providers who incur uninsured patient costs that are less than the average of all similar providers.
 - Two, a tax on all individual taxpayers.
- A complete reform of the tort system to eliminate or reduce malpractice liability.
- Create a system that terminates licensees for negligent health-care providers who would ordinarily be responsible for patterns of malpractice.
- Eliminate costly duplicative or unnecessary test that re ordered by health-care providers to avoid malpractice liability.
- Ration new technology to health-care providers based on demographically demonstrated needs, not competition, which result in cost shifting.

We must resolve our current and future dilemma in determining the cost-benefit ratio of offering advanced (and costly) medical technology that prolongs life in patients with little or no chance of recovery.

We must emphasize, as an aspect of our culture, the need for proper diet, exercise, elimination of pollutants that endanger health, stop smoking, obesity and hypertension control, and eliminate drug and alcohol abuse with national standards applied at a community level.

Please, let's not create a national health-plan insurance scheme and think that this alone will solve the problems.

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Questions from our Clients

Tina Bischoff, CFCl, Compliance Officer

Q. *An employee has asked us whether the flex credits she used for group health plan coverage under our cafeteria plan will continue during her unpaid qualifying-FMLA leave. Is there any regulatory guidance on point?*

A. Yes. In DOL Opinion Letter FMLA2006-3-A the DOL provided that if an employee uses employer-provided flex credits under its cafeteria plan to purchase group health plan coverage, the employer *must* continue the flex credits during the employee's qualifying-FMLA leave in the same amount as prior to the leave "whether or not [the coverage is] provided through a flexible spending account or other component of a cafeteria plan."

Further, if the employer "provides the money for the group health insurance coverage when employees are working, it may not recover such payments [from employees] for periods of FMLA leave."

This DOL Opinion Letter is a reminder that although FMLA does not require the maintenance of benefits other than group health insurance during an employee's leave period, at the end of an employee's FMLA leave "benefits must be resumed in the same manner and at the same levels as provided when the leave began, and subject to any changes in benefit levels that may have taken place during the period of FMLA leave." This means that "some employers may find it necessary to arrange for continued payment of costs to maintain such benefits or to pay the costs of these benefits during the period of FMLA leave in order to restore employees to equivalent benefits upon return from FMLA leave. However, the employer may recover the employee's share of those payments when the employee returns from leave."

Q. *The spouse of one of our employees has HDHP coverage under his employer that does not cover our employee. Her spouse also contributes to an HSA through his employer. Inadvertently, our employee enrolled in our general-purpose health FSA plan for the current plan year. Can our employee drop her health FSA benefit election (i.e., non-HDHP coverage) so that her spouse can contribute to his HSA?*

A. No, the employee cannot drop (or change) her health FSA because a mid-year election change event has not occurred as required under the final regulations. The oops factor in this situation notwithstanding, because your health FSA plan covers eligible medical

expenses incurred by your employee, her tax dependents and her legal spouse, her participation in your general-purpose health FSA plan made her spouse ineligible for an HSA. If your plan excluded expenses incurred by an employee's spouse, and all things being otherwise HSA eligible, her spouse could continue to contribute to his HSA.

Q. *After the current plan year started, we introduced a new HMO in an area where previously there was none. Can we allow our employees to make a mid-year election change (e.g., decrease, drop, etc.) to their health FSA benefit?*

A. No. Regardless of an employer's desire to meet their employees' welfare benefits needs, an employer cannot overrule Treas. Reg. § 1.125-4(f)(1), which does not permit any type of mid-year election changes to a health FSA benefit on account of a change in the cost or coverage of another group health plan benefit.

Q. *Is there a time line in which a one-time transfer from an IRA to an HSA should occur?*

A. It's our understanding that a one-time IRA transfer to an HSA can be made so long as the transfer for the taxable year is made no later than the filing due date (without extensions) for the individual's tax return (generally April 15th).

Q. *We offer a health FSA plan as a component under our § 125 cafeteria plan. After our current plan year started, an employee submitted a request to drop her health FSA benefit because her health insurance carrier reversed its previous decision and will now cover her chiropractor expenses after all. Can she?*

A. No, unfortunately, she cannot change her health FSA benefit election. Personal opinion aside, Treas. Reg. § 1.125-4(f)(1) places this type of event beyond an employer's control. If there's a mid-year change in the cost or coverage of a group health plan benefit, the final regulations do not permit any type of change to a health FSA.

GUEST ARTICLES

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IN DISPUTE BETWEEN NO-FAULT INSURER AND PLAN, SPD PROVISION THAT CONFLICTS WITH PLAN DOCUMENT CONTROLS

[Citizens Ins. Co. of Am. v. Pitney Bowes Software Sys. Employee Med. & Health Care Serv. Corp., 2007 U.S. Dist. LEXIS 15737 (E.D. Mich. 2007)]

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After an employee was injured in an auto accident, the no-fault auto insurer and the group health plan that covered the employee disputed which had the primary obligation to pay the medical bills. The no-fault insurer acknowledged that under Sixth Circuit precedent it would be primary if the group health plan's coordination of benefits (COB) provision (1) directly conflicted with the insurer's COB provision; and (2) expressly disavowed its primary status. The insurer also acknowledged that the COB provision in the plan document met both requirements. However, the insurer argued that the COB provision in the plan's SPD conflicted with the COB provision in the plan document, that under the SPD the plan's coverage was primary, and that the SPD trumped the plan document. The plan argued that there was no conflict between the SPD and the plan document that the plan's interpretation of the provisions was entitled to deference and could be rejected only if it was found to be arbitrary and capricious, and that even if there were a conflict, the plan document should prevail.

The court agreed with the insurer, sidestepping the question of whether the plan was entitled to deferential review, stating that the plan's interpretation was not reasonable and could not be upheld even under the deferential arbitrary and capricious standard. The court went on to dismiss the plan's argument that the plan document and the SPD were not in conflict, noting that the SPD entirely omitted any mention of an "escape clause" for no-fault auto insurance that appeared in the plan document and that the omission created a conflict. Further, the court applied the rule that when a plan document and an SPD conflict, the SPD controls. Although the plan argued that all of the cases applying this rule involved disputes between participants and plans

and that a different rule should apply to a dispute between an insurer and a plan (which are both sophisticated entities that stand on roughly equal footing), the court noted that it found no cases rejecting the application of the rule to disputes between insurers and plans and that there is a statutory duty of accuracy in SPDs.

EBIA Comment: This case allows us to emphasize, once again, the importance of an accurate and complete SPD. More importantly, though, this is apparently the first reported case in which the rule that an SPD's terms will be enforced when they conflict with the terms of a plan document is applied to a dispute between a plan and an insurer. For more information, see EBIA's ERISA Compliance manual at Sections XI.D ("Coordination of Benefits (COB)") and XXIV.L ("Conflicts Between SPD/SMM and Plan Document or Insurance Contract").

PROFESSIONAL EMPLOYER ORGANIZATION MUST PAY PENALTIES AND MEDICAL EXPENSES TO DISABLED EMPLOYEE AND SPOUSE

[Delcastillo v. Odyssey Resource Mgmt. Inc., 2007 U.S. Dist. LEXIS 18028 (D. Neb. 2007)]

(This copyrighted article originally appeared in the 03/29/2007 EBIA Weekly and is reproduced with the permission of EBIA.)

The disabled employee in this case continued to receive employer-sponsored health insurance coverage for himself and his wife for more than two years after he stopped working. When a professional employer organization (PEO) began administering the health plan, it replaced the group insurance policy that had covered the couple with a new policy from another insurer and the couple began having their claims rejected (\$27,000 in claims were pended). The PEO notified the couple that their coverage was terminated and offered them COBRA. The couple sued the PEO for damages instead, with the lower court awarding over \$300,000 in medical expenses and penalties for failure to provide timely initial and election notices, plus attorneys' fees. On appeal, however, the Eighth Circuit overturned the record award of damages and reversed the lower court in almost all respects. (See our articles at

<http://www.ebia.com/WeeklyArchives/COBRA/Co>

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[urtCases/16889](http://www.ebia.com/WeeklyArchives/COBRA/COBRA/urtCases/16889) and <http://www.ebia.com/WeeklyArchives/COBRA/COBRA/urtCases/18215> (Premium Access subscription required).) The Eighth Circuit held that, among other things, the replacement policy was not a new plan and thus did not trigger an obligation to provide a COBRA initial notice and that switching policies was not a qualifying event; rather, the subsequent termination of coverage was the qualifying event for which the PEO had provided a timely election notice. The Eighth Circuit ruled that there was no basis for COBRA notice penalties, but sent back to the lower court the issue of whether the couple could recover their unpaid medical expenses for the period of coverage under the replacement policy.

Finding that the election notice provided had been ineffective and illusory (given the PEO's bad faith in denying coverage under the replacement policy), the lower court held on remand that the PEO was liable for \$27,000 in medical expenses that would have been covered had the couple elected COBRA and medical claims improperly denied under the replacement policy. Citing the PEO's failure to provide SPDs and other plan document to the couple despite their repeated requests, the court also awarded over \$19,000 in penalties under ERISA for failure to provide requested documents (calculated at the full \$110 per day rate), plus over \$100,000 in attorneys' fees.

EBIA Comment: Because the Eighth Circuit specifically ruled that there was no basis for COBRA penalties, the lower court instead relied on ERISA's penalties for failure to provide requested documents to compensate this couple for the PEO's behavior, which it said was "egregious." Added to an award of medical expenses and attorneys' fees, this PEO paid a significant price for its administrative failings. For more information, see EBIA's COBRA manual at Section XXV ("Consequences of Failing to Comply With COBRA") and EBIA's ERISA Compliance manual at Section XXV.B ("Consequence of Failing to Furnish Documents: \$110 Per Day Penalties").

IRS RULES THAT CERTAIN CONTRIBUTIONS OF UNUSED LEAVE TO AN HRA ARE NOT TAXABLE

[Priv. Ltr. Rul. 200708006 (Nov. 17, 2006)]
For a copy: <http://www.irs.gov/pub/irs-wd/0708006.pdf>

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In this private letter ruling, the IRS confirmed that an employer may, on a mandatory and automatic basis and with no employee elections, make tax-free contributions of unused vacation and sick leave to fund health benefits payable under an HRA to eligible retiring employees and their spouses and dependents.

The employer that requested the ruling proposed to establish a trust to pay benefits due under an HRA. Only the employer would make contributions to the trust, as specified in the HRA or in resolutions of the employer. Contributions to the trust would include: discretionary contributions for all participating employees; contributions of all or a portion of employees' accumulated and unused vacation and sick leave upon retirement; and contributions of all or a portion of employees' annual excess vacation and sick leave that would otherwise be forfeited or paid out at year-end. Coverage under the HRA would be automatic for eligible employees, and they would not be allowed to opt in or out. Under no circumstances would the employees be permitted to decide the discretionary employer contributions or the amount or percentage of vacation or sick leave to be contributed to the trust. The HRA also provided that at no time may retired employees or their spouses or dependents receive unused amounts in cash or other benefits. Following a participant's death, unused amounts would be used for the benefit of his or her surviving spouse and dependents, and after their deaths, any amounts not applied to reimburse medical expenses would be forfeited.

EBIA Comment: Private letter rulings apply only to the taxpayers who request them, but they provide useful insights into the IRS's position on particular issues. This ruling confirms the IRS's approval--as previously stated in Revenue Ruling 2005-24--of HRA designs that include mandatory, automatic employer contributions (without employee election) of unused leave (see our article at <http://www.ebia.com/WeeklyArchives/CDHC/Statutes/17600> (Premium Access subscription

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required)). Addressing the flip side in a recent private letter ruling, the IRS ruled that employees' elective contributions to a post-retirement medical expense plan would be taxable (see our article at <http://www.ebia.com/WeeklyArchives/CDHC/Statutes/18899>

(Premium Access subscription required)). For more information, see EBIA's Consumer-Driven Health Care manual at Sections XXII.A ("HRAs Must Be Funded Exclusively by Employer and Not With Salary Reductions or Otherwise Under a Cafeteria Plan") and XXII.F ("No Cash-Out of Unused Amounts").

Contributing Editors: Thanks to attorney Cheryl Risley Hughes for her contributions to this article, with final editing by EBIA staff. Ms. Hughes is a principal with Sanders, Schnabel & Brandenburg, P.C. in Washington, D.C. and is a contributing author of EBIA's Consumer-Driven Health Care and Fringe Benefits manuals.

[DOL EXTENDS SUNSET DATE OF MENTAL HEALTH PARITY ACT REGULATIONS TO DECEMBER 31, 2007](#)

[DOL Reg. Sec. 2590.712, 72 Fed. Reg. 8628 (Feb. 27, 2007)]

For a copy:

<http://edocket.access.gpo.gov/2007/pdf/E7-3278.pdf>

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The DOL has amended its interim final regulations under the Mental Health Parity Act (MHPA) to extend the date on which the regulations cease to apply (the sunset date) from December 31, 2006

to December 31, 2007. The change makes the sunset date under the regulations consistent with the sunset date of ERISA's MHPA provisions, which was extended by legislation enacted at the end of 2006 (see our article at <http://www.ebia.com/WeeklyArchives/GHPM/Statutes/18833> (Premium Access subscription required)).

EBIA Comment: The MHPA prohibits a group health plan from applying a lower annual or aggregate lifetime dollar limit to mental health benefits than it applies to medical/surgical benefits. The MHPA is found in substantially similar provisions of ERISA, the Code, and the PHSa; the MHPA provisions of the PHSa and the Code have also been extended to December 31, 2007 by the 2006 legislation. For more information, see EBIA's Group Health Plan Mandates manual at Section IX ("Mental Health Benefits: Parity in Annual and Lifetime Limits").

Contributing Editors: EBIA Staff.

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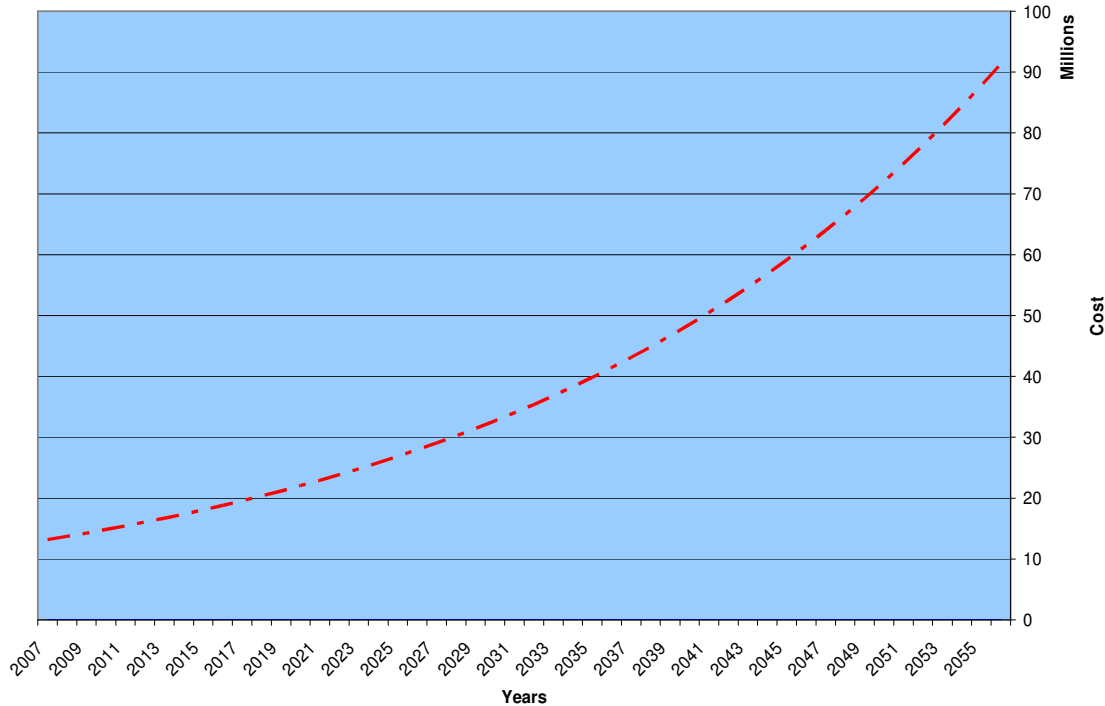
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GASB – Charts

See accompanying article beginning on page 2

Pay As You Go



The chart reflects the 2006 average cost of single coverage \$4,392 (Towers and Perrin, 2006) for 1,000 employees. The chart reflects a one percent (1%) increase in annual premium and a three percent (3%) increase in covered members over a 50 year period. The projected increase in health care for 2007 is 7.7% (Hewitt Associates, 2006).

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GASB – Charts

See accompanying article beginning on page 2

GASB Liability Chart

Example

- Employer's plan: 1,000 actives participants , 200 retirees
- State law allows retirees to participate in previous employer's plan at the same rate as active employees
- Retirees pay 100 percent of the premium
- Blended premium \$3,000

Description	Actives	Retirees	Totals
Participants	1,000	200	1,200
Blended Rate	\$ 3,000.00	\$ 3,000.00	
Paid by Employer	\$ 3,000,000.00	\$ -	\$ 3,000,000
Paid by Retiree	\$ -	\$ 600,000.00	\$ 600,000.00
Grand Total			\$ 3,600,000.00
AGE ADJUSTED PREMIUMS			
Participants	1,000	200	1,200
Age-adjusted premiums	\$ 2,472.00	\$ 5,640.00	
Paid by Employer	\$ 2,472,000.00	\$ 1,128,000.00	\$ 3,600,000.00
Paid by Retiree	0	\$ (600,000.00)	\$ (600,000.00)
Grand Total		\$ 528,000.00	\$ 3,000,000.00

Note: \$528,000 represents actual cash contributions made by the employer toward the cost of retiree coverage.

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