

Quarterly Review

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From the Desk of the Editor

I just returned from a three day Employer's Council on Flexible Compensation (ECFC) conference in Orlando. After three days of "testimony," the general consensus was that if the state of employer health benefits was on trial today, the jury is out and the verdict unpredictable. Unpredictable! Such is the current unsettled climate in all corners of the nation when it comes to strategizing healthcare for the future. Yet, talk to any HR Director and you will hear that recruiting and retention success directly correlates to benefits offered at the workplace. In fact, data gathered by Kaiser Family Foundation over the past ten years indicates that the average percentage of Employers with 200+ employees who provide health insurance coverage has fluctuated only between 98 and 99%. Employers continue to provide benefits because employees continue to expect benefits. States have demonstrated that they expect employers to provide benefits. In this issue, we continue the discussion about individual health mandates Massachusetts style (which means employers have a mandate to provide certain coverages albeit indirectly). There's an article from a new contributor citing the merits of offering voluntary products at the worksite and an article regarding wellness programs. Even the federal government as an employer, recognizes the importance of offering benefits. I heard recently on NPR that to fill its impending labor shortage due to us boomers, health and retirement benefits are being enhanced to become the big draw to encourage employment with the federal government. The unpredictability factor comes with the many unknowns related to the upcoming presidential and probably more importantly senate elections. Ever feel like a ping pong between the Ds and Rs and let's not forget the Feds and the States?

This quarter's feature is the newly proposed FMLA rules and how the rules will impact employers. Researching this article lead me to some employee advocate BLOGS on the internet that raised concerns about the loss of privacy the new rules permit. Although an employer behaving badly could abuse under the new rules, as employers many of us have experienced first hand employee abuses under the current rules – there are some welcome changes.

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There's good news for electronic payment card customers and employer sponsors regarding an industry produced and accepted listing of eligible health-related expenses. Hopefully card vendors and processors will all be on the same page in approving health related expenses through their cards.

Senator McKnight offers his perspective about HSAs and a recent House Bill that would jeopardize their effective continuation just as employers begin to embrace HSAs. Will it pass?

There are other articles designed to provide you with regulatory information – I will leave you to scan and select those of interest. Enjoy.

Trish Neely

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A Perspective from the Hill

Robert McKnight, Senator

The landmark Health Savings Account (HSA) legislation may be changing. As most of you may recall, the legislation cleared both chambers in the darkness of night. A major delay to passage was allegedly the signoff by the large financial players interested in the trustee portion of the legislation. In their haste, the policy makers apparently gave little thought to the particulars of adjudication of claims under the new tax policy.

Now, the House Ways and Means Committee has approved a "house keeping" bill sponsored by the

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powerful chairman of the committee, Charles Rangel (D., NY) that will limit the tax exclusion for HSA distributions to medical expenses that are substantiated according to flexible spending arrangement rules.

The legislation, known as *The Taxpayer Assistance and Simplification Act of 2008*, was supported by the Democrats on the committee and opposed by the Republicans. In fact, Republican Congressman Ryan filed an amendment opposing the substantiation requirement, arguing that the members had only anecdotal information on the effect of HSAs and health costs. Ryan's amendment was defeated along party lines.

It was widely rumored on the hill that the Rangel bill was advanced by a vendor which would financially gain by the adoption of the legislation---where have we heard that before?

It is argued that the substantiation requirements would place banks in a difficult position with their customers, would require banks to comply with HIPAA and increase costs. Many banks and small businesses don't have the capability to deal with this new legislation.

It should be noted that substantiation is not required for other tax advantaged savings vehicles, like the itemized deduction for medical expenses, home equity loan deduction and the exceptions to the 10% early withdrawal tax for certain distributions from an IRA.

According to Congressional Joint Tax Chief Kleinbard, there will be fewer contributions to HSAs as a result of the proposed legislation, and the 10% tax will be paid on more distributions. Kleinbard agreed with the Republicans that the revenue estimate, even including the delayed effective date, is significant.

Depending on how you come down on this issue, many observers feel a sense of relief that the framers of our federal governance system required passage by another body for any legislation to be eligible for enactment by the President. Next battle on this issue will rest with the United States Senate...stay tuned.

Feature Article

FMLA New Proposed Rules

Trish Neely, CFCI
Karen Gilliard

In the January Quarterly Review we looked at the changes to the Family Medical Leave Act of 1993 (FMLA) resulting from the National Defense Authorization Act of 2008 (effective 1/28/08). This issue

we will tackle the full breadth of the 120+ page proposed rules. The full text may be found at: www.dol.gov/esa/whd/fmla/FedRegNPRM.pdf

From an employer perspective we were hoping for more. Since FMLA has been the subject of controversy and legal challenges since its inception, we expected better definitions and clarity in these new proposed rules to help us administer FMLA. Interpretation invites dissension and can cause abuse on any and all sides of the labor aisle.

We are not alone. Determining what is and what is not a "serious health condition," enforcing "intermittent leave," and verifying "medical certification and disclosure" have been the topics of workshops, debates, and litigation throughout the nation – no industry is immune to the difficulties inherent in administering the current FMLA rules.

If you are not intimately familiar with the current Act's trouble spots for employers and employees alike, the Department of Labor (DOL) discusses these challenges in detail in its preamble to the new rules. Interestingly, although they are cited, they are not in our opinion all satisfactorily addressed.

What is a serious health condition? A period of incapacity of more than three calendar days and requires an employee to visit a healthcare provider twice within 30 days. Still a little unclear? So are we. However, we acknowledge that it is a slight improvement over the current open ended time frame.

Chronic serious health conditions would require periodic visits to a healthcare provider; with **periodic** now defined as twice per year.

Certifications

Medical Certification

The proposed rules would **remove** the requirement upon the employer to apply the same standards on certifying and documenting FMLA leave as it does non-FMLA leave (often less stringent).

Employers would be permitted to require more medical information if the certification is deemed by the employer to be "insufficient." Currently an employer must accept the certification as completed by the employee's healthcare provider.

If a deficiency is identified, the employer would then be required to give an employee seven calendar days to cure any deficiency.

On the newly revised certification forms, healthcare providers will now be required to certify that intermittent

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or reduced schedule FMLA leave is medically necessary.

Under the new rules an employer may request to speak directly with the healthcare provider to authenticate or clarify the medical certification, and if the employee refuses, FMLA leave rights may be jeopardized and FMLA leave denied.

Employers would be allowed to request recertification every six months for conditions that are of an indefinite duration.

The new rules would recognize a physician's assistant (PA) as able to complete the certification form. This may or may not be good news for employers.

Fitness for Duty Certifications

Under the new rules employers would be allowed to present the employee's healthcare provider with a listing of the employee's essential duties and the healthcare provider would have to certify that the employee could safely perform the duties. Currently the fitness for duty certification only needs to provide that the employee may return to work.

Employers would also be permitted to request the certification every 30 days for intermittent FMLA leave if safety concerns exist. The current rules do not give employers the right to request a fitness for duty certification with intermittent FMLA leave.

From an employer perspective this is sound risk management but employee advocates fear that anti-FMLA employers will become unusually and perhaps unreasonably concerned about an employee's safety.

The new rules clarify that time spent on light duty assignments do not count against an employee's leave entitlement under FMLA.

Intermittent leave

Under current rules intermittent leave may be taken in the shortest unit of unpaid leave established by an employer's payroll/timekeeping system. The proposed rules have left this provision untouched. DOL has determined that it does not have the authority to alter incremental leave practices.

Under the proposed rules, employers would have the right to send the employee's absence record to the healthcare provider and to ask if the pattern of absence is "congruent with the employee's qualifying medical condition."

Coordination with other Leave

The proposed rules clarify that unpaid FMLA leave runs concurrently with paid leave. Currently employees must follow an employer's paid leave policy in order to utilize accrued paid leave for FMLA leave.

Giving Notice

ER Requirements

Employers must still post notices of general rights and responsibilities. Employers are also required to annually distribute a notice of FMLA rights to each employee. This can be done through your handbook, mail distribution or your intranet.

Employers would be given 5 days instead of the current 2 days to convey eligibility for FMLA leave, and to provide notification that FMLA leave is approved or denied.

An employer would also be given 5 days rather than the current 3 days to request a medical certification form.

The new rules propose eliminating language that an employee is deemed eligible for FMLA if he/she has not received proper notice of his/her FMLA rights. (*From US Supreme Court decision in Ragsdale v. Wolverine World Wide, Inc.*)

The new rules clarify that "**calling in sick**" is not sufficient to trigger an employer's obligations under FMLA.

EE Requirements

The DOL takes the position that employees should provide notice of a need for leave the same day or next business day that they discover the need. Under current and new rules employees **must** provide 30 days notice of a need for FMLA leave when the leave is foreseeable.

When a leave is unforeseeable and/or an employee provides less than 30 days advance notice, an employer may request an explanation of the delay.

Additionally, an employee must **make a reasonable effort** not to disrupt an employer's operations. Currently an employee must **make an attempt** when scheduling leave.

Care for others

An employee requesting FMLA leave to care for a family member no longer would have to prove he/she is the "only" individual available to provide the care.

Settling disputes

In keeping with a recent court case, employees would be permitted to voluntarily settle past FMLA claims

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directly with the employer. Currently the employee must seek permission from the DOL or a court. Stay tuned, because the court case is winding its way to the Supreme Court.

Effective Date: Pending; in the interim, employers should continue to follow the current regulations.

The revisions were released 2/11/2008 and the Department of Labor (DOL) sought comments from employers and employees through 4/11/2008 (60 days).

The DOL review period will be long or short depending upon the volume and type of comments received.

Congress also has the ability to modify or reject the revisions and/or delay passage. If it is delayed long enough the outcome of the presidential election could also impact what is included in the **final** rules.

FMLA Basics

FMLA provides up to 12 weeks of unpaid time off in any 12-month period as family and medical leave.

The National Defense Act amended FMLA to provide up to 12 weeks of leave for any qualifying exigency if an employee's family member is called to active duty; and up to 26 weeks of leave is provided to family members of a service member injured during active duty.

To be eligible for FMLA leave, an employee must have worked 12 months and have 1,250 hours of service.

Electronic Payment Cards SIGIS Creates Gold Standard for IIAS

Kendall Hall
Trish Neely, CFCI

Ever wonder how card processors and administrators were going to sift through the thousands of products offered at grocery stores and pharmacies and determine which ones to approve and to reject, and by the way do it real time for customer convenience without significantly increasing the pricing model for cards? We did. We also wondered how merchants, vendors, and card processors could be held to approving only eligible 213(d) expenses and who would monitor to keep everyone honest and the industry on good terms with the IRS. The solution to these questions and many others was the formation of an industry group – **Special Interest Group for IIAS Standards**, known simply as **SIGIS**. FBMC is an active member of this group.

Some background. The IRS made the use of electronic

payment cards a reality with Revenue Ruling 2003-43. Cards were to be used only for eligible health care expenses. Restricting cards to merchants with **health Merchant Category Codes (MCC)** was a solution. Many card processors also permitted the cards to be used at grocery stores and discount retail stores as long as cards could be restricted to specific terminals (i.e. in-store pharmacies). The IRS became increasingly concerned with stories of lawn chairs, soda, and other non-health related expenses being purchased along with prescriptions. So, three years later Revenue Ruling 2006-69 was issued which made it mandatory for all grocery / discount retailer stores and drugstores to implement an **Inventory Information Approval System (IIAS)** to assure expenses were legitimate health-related expenses. The devil is always in the details, and this was no exception. With much lobbying by members of ECFC (Employers Council for Flexible Compensation) and others an extension was granted such that Grocery, retail, and mail order RX stores were given until the end of 2007 to implement IIAS and Drugstores until the end of 2008. The efforts of the "lobbying group" then shifted to a search for a standard solution and SIGIS was formed.

Fast forward to today. SIGIS consists of all the key players in the electronic payment card arena: employers, TPAs, Administrators, Health plans, Issuers/Processors, Payment Card Networks, Merchant Acquirers and Merchants. Membership currently includes most national grocery store and pharmacy merchants; smaller regional and Mom & Pops are added weekly. In addition to creating and maintaining (in accordance with IRS regulations) **THE** Eligible Products List which is the basis for IIAS, SIGIS also offers a certification program for merchants indicating their compliance with standards, and plays the industry watch dog role in investigating reported infractions of the standards.

Having one standard product list of eligible 213(d) expenses levels the playing field for all parties. The concern that smaller merchants would be left without a solution has been addressed. The employer/plan sponsor fear that each administrator and card processor would use different lists resulting in customer confusion has been addressed. Administrator's concerns that competitors might use more liberal lists resulting in further IRS restrictions has been addressed. This is a great enhancement for all of us as we will not be required to ask for documentation for any purchases made at IIAS-certified stores, thereby making electronic payment card use more straightforward for card participants. Even *more* exciting is to see the merchant world come together with the Visa and MasterCard associations to make this work!

For additional information, please contact khall@fbmc.com or log on to the SIGIS site at

sig-is.org.

Steps to 403(b) Compliance

Patrick Peters, President
Vista Management Company

The 2007 final regulations under IRC Section

403(b) introduced new compliance requirements for employers to follow. Whether you currently have, or are contemplating introducing a 403(b) retirement plan as part of your program, it is important for you to understand and comply with these requirements. We have listed the Steps to Compliance below. For additional information, the October 2007 issue of this newsletter discussed the final regulations in detail.

Step 1 – Adopt the Plan

Effective January 1st 2009, any employer that offers §403(b) salary reductions must formerly develop and adopt an IRC compliant 403(b) Plan Document (model language) or seek a private letter ruling on the plan document that is substantially different from the IRS provided model language. The written plan can incorporate by reference other documents including annuity contracts and custodial agreements, which as a result of such reference become part of the Plan. The Plan Document supersedes all other contracts and agreements relative to the operation of the 403(b) plan. All section 403(b) contracts purchased for individuals by an employer are treated as purchased under a single contract for purposes of the requirements of section 403(b). The Plan Document should incorporate by reference the requirements of the Information Sharing Agreement.

Step 2 – Execute Information Sharing Agreements

An employer must develop and execute Information Sharing Agreements (ISA) with **all** approved 403(b) providers. This includes gathering information from current and former providers with whom an employer has remitted 403(b) salary reductions.

Step 3 – Tighten up Plan Administration Procedures

An employer must develop criteria for current or former providers to be "*Approved Providers*" and maintain a listing of approved providers who have agreed to the Information Sharing Agreement.

Select an independent Benefit Administrator to provide the following services.

- ✓ Common Remitter Services to effectuate timely disbursement of participant funds to provider companies;
- ✓ Oversight of the following participant services in accordance with the plan document:

Loans
Hardships
In-service distributions
Qualified Domestic Relations Orders (QDRO)
Contributions changes
Participant notifications;

- ✓ Limits testing – 402(g); 403(b) and 414(v) catch-up provisions, 415 limits;
- ✓ Oversight of access to participant account through provider portal;
- ✓ Provider services, including:
 - Provider qualification
 - Product education and benefit fairs
 - Provider conferences.

Step 4 – Develop Compliance Procedures for Exchanges and Transfers

Incorporate the procedures in the written Plan Document and limit transactions to only companies that meet the stated exchange and transfer requirements.

These procedures should include:

- Changing investments within the same plan
- Plan to plan transfers
- Purchase of permissive service credit (repayment of defined benefit governmental plan)

Step 5 – Prepare for Other Compliance & Reporting Requirements

- Universal Availability – annual notification of qualified employees right to participate in the 403(b) plan
- Discrimination Testing
- Provider performance audits

For additional information you may contact the author at ppeters@fbmc.com.

Health Care Trends

Voluntary Products In Focus

Desso H. Forman, CDHC

Health care is in crisis and many solutions are being considered, including reengineering health care access and delivery systems. In our opinion there will always be a need and therefore a role for employers in providing a full range of benefits including health benefits at the workplace, but I suspect I am preaching to the choir.

While the candidates and politicians at the States and Federal level debate the issues and proffer their

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solutions, pressure increases on employers to provide a quality benefits package. We may not know where the health care debate shakes out for several years, but we do know the value here and now voluntary benefits can bring to an employer and its employees.

So, why would a company want to add voluntary benefits to its menu of benefit offerings? Consider...

Voluntary products can fill gaps in core coverages that an employee is willing to pay for.

Voluntary products are portable at the same cost. Unlike most core benefits, voluntary products can continue on a direct bill basis at the same cost.

A stronger benefits package may be the difference in hiring and retaining your best employees. As the average age of the US climbs, competition for finding and hiring experienced qualified employees will only grow fiercer.

Voluntary products can result in more customization by the employee of his or her benefits package. Most everyone has a different need and as the employee ages, life event changes may necessitate changes in the employees overall benefits package. Maybe term life is of greater value for the younger worker but as he or she ages, long-term care may then come to the forefront.

Worksite marketing of voluntary products is not new, but employers are gaining interest fueled in part by the need to remain competitive during the boomers pending retirement years and also importantly by advances in technology for enrolling and managing voluntary benefits. An Eastbridge Consulting, Inc. survey chart illustrates this upward trend.

EMPLOYEE OWNERSHIP OF AT LEAST ONE VOLUNTARY PRODUCT

EMPLOYER SIZE	PERCENT	
	2002	2006
10 to 100 employees	33%	54%
101 to 500 employees	44%	66%
501 to 2,000 employees	42%	76%
2,001 or more employees	43%	69%
Weighted average reflecting actual employee mix in the U.S.	40%	65%

Product considerations . . .

Strategically what does the employer need to meet its objectives? An employer would need look over its core benefits and locate gaps. An example might be that ABC Company has long-term disability but no short disability along with a weak sick leave policy or no policy at all.

What do employees want and need? A survey listing the products, a description of how they work in non-technical language along with a request to employees to rank in order of need or importance, can facilitate this process.

As you can imagine, there are many A-rated companies offering voluntary products in the following basic categories:

- Life
- Disability
- Gap or hospital indemnity coverage
- Accident
- Cancer
- Critical illness
- Long term care
- Mini-med – A limited medical insurance plan

Delivery methods . . .

- A separate enrollment offering the voluntary products where an enrollment firm presents the products to the employees.
- Group meetings with voluntary sign up to meet with a benefit specialist to enroll.
- An enrollment process where all employee benefits are enrolled through one-on-one meetings with a benefit counselor.
- Web enrollment.
- Call center enrollments
- A combination of any of the above.

According to a 2008 Eastbridge Consulting Group, Inc. study of enrollment methods for these products, the greatest participation by employees was a one-on-one method with an enrollment specialist. One-on-one was 35 to 60% with group meetings coming in next at 20-50% participation.

Voluntary benefits can fill the needs of employees who want to customize their personal insurance coverage. For employers, it can enhance the benefit offerings in an economical fashion as an employee pay program.

For additional information on this topic, contact dforman@fbmc.com. Desso recently obtained his CDHC certification through the National Association of Health Underwriters (NAHU).

Wellness programs and incentive plans

Murielle Etienne

HIPAA's nondiscrimination provisions prevent a health plan from discriminating against an individual based on

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health factors, however the rules also allow plans to establish wellness or incentive plan to encourage participants to take part in health education and disease-prevention programs. On December 13, 2006, the Departments of Labor, Treasury, and the Department of Health and Human Services issued final HIPAA nondiscrimination and wellness program regulations. These final regulations were effective February 12, 2007 and apply to plan years beginning on or after July 1, 2007. The final regulations provide requirements that must be met in order for a group health plan to provide an incentive based on participation in the program. Incentives often take the form of discounts or rebates, additional flex dollars, or changes to co-payments or deductibles, which may require adjustments to cafeteria plan elections. To review the Nondiscrimination and Wellness Programs in Health Coverage in the Group Market; Final Rules please visit:

<http://a257.g.akamaitech.net/7/257/2422/01jan2006180/0/edocket.access.gpo.gov/2006/pdf/06-9557.pdf>

The Department of Labor recently released, Field Assistance Bulletin (FAB) 2008-02 which provides guidance to the final HIPAA wellness program regulations discussed above. The FAB contains a list of questions to help determine whether a plan is offering a health promotion or disease prevention program that is required to comply with the final wellness program regulations and if so, whether the program is in compliance with the regulations. If the answer is "NO" to any of the 5 questions then the plan has a wellness program compliance issue. To review the Field Assistance Bulletin No. 2008-02 please visit: <http://www.dol.gov/ebsa/regs/fab2008-2.html>

There are wellness incentives programs that are not subject to HIPAA regulations which include the following:

1. Incentives programs that are not a part of a group's benefit plan and do not affect the benefit's plan design or the cost to the participants.
2. Wellness program participation that does not result in a monetary reward (i.e. wellness assessments, informational materials and a telephone help line).
3. Incentives programs that offer favorable terms for eligibility, benefits or contributions to individuals with undesirable health conditions over ones offered to individuals with no health problems.
4. Incentives that can be obtained through participation and not as compensation for achievement of a result.

Although programs that are not part of the health plan can be designed with more flexibility, and cash

incentives are taxable. By way of example, FBMC recently implemented a weight loss incentive program, "The New You." The program's objective was to encourage employees to achieve a healthier weight through proper diet and exercise. The wellness team held weekly weight-ins and offered weekly meeting conducted by fitness and nutrition professions to discuss ways of becoming the new you. At its conclusion, successful participants received a modest compensation of \$50 for losing 5% of their current body weight and \$100 for losing 10% or more.

The program did not have to comply with the HIPAA wellness program regulations because the plan was not offered as a part of our group health plan which meant the team had fewer restrictions to follow and more flexibility, the team and the participants were surprised to learn that their cash incentives were subject to tax. Lessons learned for the future.

Bottom line: Unless wellness incentives are provided as part of a health benefit plan any cash payment or cash reward (i.e. gift cards, pre-paid debit cards) are considered fully taxable wages and must be included in the employees' taxable income.

States Mandate Section 125

FBMC Staff

Connecticut

Effective 10/1/2007

Any employer that provides health care benefits through payroll deduction must offer employees ability to pre-tax premiums through a Caf  Plan.

Rhode Island

Effective 7/1/2009

Any employer with ≥ 26 employees must offer a Caf  Plan for employees to pay for self and dependent health insurance coverages.

Missouri

Effective 1/1/2008

Any employer with **insured health coverage** must establish a premium only plan under   125. This does not apply to self-insured or self-funded group health plans.

More on the Massachusetts Health Care Reform Act (MHCRA)

Trish Neely, CFCI
Bernie Smith

We reported in the January issue of QR that for any employees living in Massachusetts, an employer is required under MHCRA to distribute

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statements and file certain reports by Jan. 31, 2008. This quarter's article provides an update to help employers prepare for 2009.

Individual Health Mandates

Although the Act does not require Employers to offer specific health benefits, Massachusetts residents are compelled by the Act's individual health mandate to seek coverage that meets certain minimum creditable coverage standards. It does not matter where a resident's employer is domiciled for purposes of meeting the individual mandate.

State residents who are **1) active participants** in any type of employer-provided plan (fully insured or self-funded), **2) COBRA beneficiaries** or **3) retired** participants who are not enrolled in Medicare must comply with the minimum standards.

HR Directors take note:

*If you as the employer do **not** provide the minimum coverage, your employees residing or working in Massachusetts must seek that minimum coverage elsewhere or risk a penalty by the State for noncompliance with the Act.*

An employer with one or more employees residing in Massachusetts must provide such employee(s) with the information necessary to demonstrate he/she/they meet minimum creditable coverage standards.

We are providing the following information to assist you as you begin renewal discussions with your health carriers, unions or employer groups. The 2009 minimum creditable coverage health mandate for individuals residing in Massachusetts will include:

- ✓ Primary and preventive care
- ✓ Emergency services
- ✓ Hospitalization benefits
- ✓ Diagnostic surgery
- ✓ RX coverage with \$250 individual deductible and separate \$500 family deductible
- ✓ Outpatient services
- ✓ Mental health services
- ✓ No annual or per illness maximum
- ✓ No per-day limit on in-patient care
- ✓ Annual deductibles of \$2,000 for individual coverage and \$4,000 for a family plan

- ✓ Annual out-of-pocket caps for in-network services of \$5,000 for individual coverage and \$10,000 for a family plan
- ✓ A minimum of 3 doctor visits for an individual and 6 for a family before any upfront deductible.

Massachusetts-domiciled Employer Requirements

- Free-Rider Surcharge
- Fair Share Contribution
- Health Insurance Responsibility Disclosure (HIRD) Form
- Health 1099 Form

For additional information log on to the Massachusetts Health Connector website: www.MAhealthconnector.org. The site is easy to navigate and will provide you with information and with access to resources necessary to comply.

2007 Product of the Year Award

Celeste Pullen, AVP
Customer Services

Last month Syntellect was honored with the 10th annual **Product of the Year Award** by Customer Interaction Solutions Magazine, a Technology Marketing Corporation's publication. Syntellect owns **Apropos Technologies**. If this name sounds familiar, it is because we currently use the Apropos customer interaction management solution in our Tallahassee and Ormond Beach, FL call centers; we will be transitioning to Apropos this summer at our Cherry Hill, NJ office.

The honor is well-deserved. In 2004, following an extensive RFP review process, we chose Apropos as our customer interaction management solution to improve service delivery to our clients and customers. Since that time we have enjoyed many benefits of the system including expanded customer self service options provided by our Interactive Voice Response system, real-time call center monitoring enabling us to realize how many customer calls and emails are holding at any given time and how long they have been holding, client specialized "message of the day" capabilities, and an improved reporting tool that we rely upon heavily in our daily call center operation just to mention a few of the features of our system. The investment in Apropos' solution has also enabled FBMC to better utilize our call center staff, provide more options to our clients, and give us better data for planning purposes.

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To paraphrase the remarks of Nadji Tehrani, editor-in-chief of the publication, Syntellect was selected because it had proven its dedication to quality and excellence in solutions that benefit the customer experience as well as it provides return on investment to employers or vendors who utilize its systems.

Who's your PAPI?

Chet Hall, Chief Information Officer

www.myFBMC.com continues to evolve. PAPI, FBMC's new Web based user application front-end interface, was successfully launched in January of 2008 offering tighter security while providing a better means of communicating with customers and offering enhanced services.

PAPI eliminates the need to use Social Security Numbers (SSN) when customers logon to access personal account information.

PAPI (Premier Application Participant Interface) provides enhanced security by registering each user (customer) using a three tiered approach. When a user first visits the [myFBMC](http://www.myFBMC.com) site, he/she is required to enter name, mailing zip code and email address. Next the user **MUST** enter one of the following: FBMC ID; Employee ID; or SSN. This is our way of assuring the user is who he/she claims to be. Finally, the user enters a secure password and validates an image of scrambled letters and numbers. All of this helps prevent unauthorized access to personally identifiable or protected health information. After this information is validated the user is sent an encrypted email which verifies the email address and asks the user to confirm the registration by clicking a link in the email. The user can now be identified within our systems as a valid user/customer.

Once this registration process is concluded, we (FBMC) can begin using the email address of the customer(s) to provide better service with online communication. Currently customers use email to send inquiries and scanned documents to, and receive responses from, our Call Center. Today Customers may also use email to change a "forgotten" password via self service.

Our future plans include using emails to confirm receipt and payment of claims, validate web enrollments and inform users of card transactions. All part of a corporate-wide Go Green initiative.

Critical from a security standpoint, PAPI has eliminated the need for a customer to logon using SSN to view personal account information. Once registration is complete a customer logs on using only email address and password. For clients and/or customers who wish or need to continue to use SSN, it remains an option available to use in the registration process.

If you have not logged on to [myFBMC](http://www.myFBMC.com) this year, please do so and see what FBMC is doing to provide a better user experience for you and your employees.

GUEST ARTICLES

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ERISA DOES NOT PREEMPT STATE INSURANCE DIRECTIVE INCORPORATING MAKE-WHOLE DOCTRINE

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[Benefit Recovery, Inc. v. Donelon, 2008 WL 642972 (5th Cir. 2008)] For a copy: <http://www.ca5.uscourts.gov/opinions%5Cpub%5C07/07-30414-CV0.wpd.pdf>

The "make-whole" doctrine is an insurance principle that provides that an insurance company may not enforce its subrogation rights until the insured has been fully compensated for his or her injuries--that is, made whole. In this case, a third-party recovery company challenged an insurance commissioner's directive that incorporated the "make-whole" doctrine by mandating that any right of an insurer to recover from third parties, whether by subrogation or reimbursement, had to be subordinate to the insured's right to be fully compensated. The company argued that the directive was preempted (that is, superseded) by ERISA.

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The Fifth Circuit disagreed, holding that the directive was saved from preemption under ERISA's exception for laws that regulate insurance. Affirming the trial court, the Fifth Circuit ruled that the directive regulates insurance because (1) it was directed at insurers in that it specifically required them to include certain terms in their policies, and (2) it substantially affected the risk-pooling arrangement between insurers and insureds "by telling them what bargains are acceptable."

EBIA Comment: Many states have enacted insurance laws that restrict insurers' reimbursement or subrogation rights where the insured has not been made whole. As this case illustrates, insured ERISA plans are subject to these state laws to the extent the laws are saved from ERISA preemption. Moreover, although these state laws are preempted as to self-insured ERISA plans, some federal courts have created "federal common law" that fills the gaps in ERISA and applies make-whole principles to self-insured ERISA plans. But most courts refuse to apply the make-whole doctrine to self-insured ERISA plans where applying that doctrine would conflict with the plan's terms. For more information, see EBIA's ERISA Compliance manual at Sections XI.C.3 ("Subrogation/Reimbursement May be Limited Where Participant is Not 'Made Whole'") and XXXIX.D ("Certain State Insurance Laws Are Saved From Preemption").

Contributing Editors: EBIA Staff.

PROPOSED REGULATION ON TRICARE INCENTIVE PROHIBITION ADDRESSES TREATMENT OF CAFETERIA PLANS

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[TRICARE; Relationship Between the TRICARE Program and Employer-Sponsored Group Health Plans, 32 CFR Part 199, 73 Fed. Reg. 16612 (Mar. 28, 2008)]
For a copy:

<http://edocket.access.gpo.gov/2008/pdf/E8-6419.pdf>

The Department of Defense (DoD) has issued a proposed regulation regarding the TRICARE incentive prohibition which prohibits employers from offering financial or other benefits to TRICARE beneficiaries as incentives not to enroll (or to terminate enrollment) in employer-sponsored health plans that otherwise would be primary to TRICARE. (For more information about this prohibition, see our articles at <http://www.ebia.com/WeeklyArchives/GHPM/Statutes/18744> and <http://www.ebia.com/WeeklyArchives/GHPM/Statutes/18756> (Premium Access subscription required).) The regulation states that an employer may not offer

TRICARE beneficiaries an alternative to the employer primary plan unless: (1) the beneficiary has primary coverage other than TRICARE; or (2) the benefit is a Code Section 125 cafeteria plan that is offered to all employees, including employees who are not TRICARE eligible employees. The regulation further provides that the TRICARE incentive prohibition "applies in the same manner" as the prohibition against offering incentives under the Medicare Secondary Payer (MSP) rules. Also included are provisions regarding remedies and penalties, as well as definitions of a few key terms.

The preamble to the regulation clarifies that an employer-provided incentive not to enroll in a group health plan generally does not violate the TRICARE incentive prohibition if the incentive "is available to and can be used by all employees." Thus, certain common employer-provided benefits are not improper incentives. For example, supplemental insurance offered under a cafeteria plan would not be improper, so long as it is not a "TRICARE-exclusive plan." Moreover, an employer-sponsored cafeteria plan is not a prohibited incentive if it offers all employees (without regard to TRICARE eligibility) a choice between health coverage and cash payments. The preamble also notes that TRICARE-exclusive supplemental insurance plans may not be offered as an option for health coverage under an employer-sponsored group health plan. Further, such TRICARE-exclusive supplemental insurance plans cannot be included in a cafeteria plan because they are not open to all employees and would be "an improper incentive targeted only at TRICARE beneficiaries for not enrolling in the employer's main health plan."

EBIA Comment: The TRICARE incentive prohibition applies beginning January 1, 2008 to all employers (except those with fewer than 20 employees). The DoD had previously indicated that the TRICARE incentive prohibition regulation would not consider a Code Section 125 cafeteria plan to be an unlawful incentive so long as all plan participants are treated the same (see our article at <http://www.ebia.com/WeeklyArchives/GHPM/Statutes/19125> (Premium Access subscription required).)

Although the regulation is only proposed at this point, employers that are subject to the prohibition may want to familiarize themselves with the regulation and its preamble. The prohibition against offering financial or other incentives must be taken seriously--civil penalties of up to \$5,000 can be imposed for each violation. For more information, see EBIA's Group Health Plan Mandates manual at Sections XXVII.D ("TRICARE: Prohibition Against Financial and Other Incentives Not to Enroll in a Group Health Plan") and XXIV.D.4 ("MSP Requirements: Prohibition Against Offering Certain Incentives"); see also EBIA's Cafeteria Plans manual at Section XVII.B ("TRICARE Incentive Prohibition and

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Cafeteria Plans").

Contributing Editors: EBIA Staff.

AT LAST! EEOC ISSUES FINAL REGULATIONS ALLOWING EMPLOYERS TO COORDINATE RETIREE HEALTH BENEFITS WITH MEDICARE ELIGIBILITY

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[29 CFR Part 1625, 72 Fed. Reg. 72938 (Dec. 26, 2007)]

For a copy:

<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/E7-24867.pdf>

The EEOC has published final regulations that permit employers to coordinate retiree health benefits with Medicare (or comparable state health programs) without violating the federal Age Discrimination in Employment Act (ADEA). (The ADEA prohibits covered employers from age discrimination against employees or job applicants who are at least 40 years of age, and it is the EEOC's view that the ADEA also prohibits age discrimination against retirees.) Under these regulations, created under the EEOC's statutory authority to issue ADEA exemptions, it is permissible for employee benefit plans to provide health benefits for retired participants that are altered, reduced, or even eliminated when the retired participant is eligible for Medicare health benefits or for health benefits under a comparable state health program (whether or not the retiree actually enrolls in Medicare or the state health program). In addition, the exemption allows employers to alter, reduce, or eliminate health benefits for spouses or other dependents of retirees when the dependents are eligible for health benefits under Medicare or a comparable state program, whether or not the retirees' own health benefits are similarly altered, reduced, or eliminated. The exemption applies to existing, as well as newly-created retiree health benefit plans. However, the EEOC notes that the exemption is very narrow: (1) no other aspects of ADEA coverage or employment benefits other than retiree health benefits are affected by the regulations (e.g., the exemption does not apply to health benefits for current employees); and (2) the exemption, which concerns only the ADEA, doesn't affect any non-ADEA obligation that employers may have under Medicare or any other law (such as an employer's obligation to observe the Medicare secondary payer rules).

The final regulations, effective December 26, 2007, are identical to the proposed final regulations issued in April 2004. The preamble, however, provides additional information regarding the EEOC's reasoning behind issuing the exemption, as well as a summary of the

protracted litigation that delayed issuance of the final regulations for several years. (See our article on the 2004 proposed regulations at

<http://www.ebia.com/WeeklyArchives/GHPM/Statutes/17685> and our most recent article on the litigation at <http://www.ebia.com/WeeklyArchives/GHPM/CourtCases/19042> (Premium Access subscription required).)

EBIA Comment: As the EEOC noted, most employers aren't legally obligated to provide retiree health benefits, and many don't offer them at all. However, employers who do offer such benefits (and their advisors) will likely welcome the final regulations, which are intended to help employers create, adopt, and maintain a wide range of retiree health plan designs, such as Medicare bridge plans and Medicare wrap-around plans. Employers are now free to supplement a retiree's Medicare coverage without having to demonstrate under the ADEA that the coverage is identical to the health coverage of non-Medicare eligible retirees or that the cost of the coverage was the same. Although the litigation isn't over (AARP has recently asked the U.S. Supreme Court to review the Third Circuit's decision), the EEOC regulations are now law and can be relied upon. Thus, employers offering retiree health benefits may wish to discuss their Medicare coordination options with their advisors. For more information, see EBIA's Group Health Plan Mandates manual at Sections XIX.D ("Retiree Health Benefits and the ADEA") and XXIV ("Medicare Secondary Payer (MSP) Requirements").

Contributing Editors: EBIA Staff.

FBMC Comment: On March 24, 2008 the Supreme Court refused to review AARP's challenge. This is good news for employers who may continue to maintain a wide range of retiree health plan designs for aging boomers; however this is not good news for some Medicare beneficiaries.

QUESTION OF THE WEEK

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QUESTION: Our company has three 401(k) plans that are tailored to each of our different businesses. Some employees transfer among these businesses, and they end up participating in more than one plan in the same taxable year. Whose responsibility is it to keep them from exceeding the annual limit on elective deferrals under Code Section 402(g)?

ANSWER: This is a common problem. When an employee leaves your company for an unrelated company, the employee is responsible for ensuring that the combined deferrals under both companies' plans do

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not exceed the annual deferral limit. But when an employee transfers among 401(k) plans within your company, your company must monitor that employee's annual deferral limit--just as it must monitor the limit when the employee participates in just one of your plans for the year.

==> Applying the Annual Limit Under Multiple Plans. As you know, the Code limits each participant's annual elective deferrals into your company's 401(k) plan. The limit for 2008 is \$15,500 (as adjusted for inflation) and applies to the participant's taxable year (typically, the calendar year). The limit applies to all elective deferrals that a participant makes under your company's 401(k) plans, unrelated employers' plans, and other similar plans (such as 403(b) and SIMPLE plans) during the taxable year. For example, if an employee works for two employers and participates in each of their 401(k) plans during the same taxable year, then the combined elective deferrals (including any designated Roth contributions) under both plans are subject to the limit.

==> Excess Deferrals in Plans of Related Businesses. As a qualification requirement, each of your company's 401(k) plans must ensure that the deferrals made under all plans within your company's controlled group do not exceed the annual deferral limit, and they must not hold any "excess deferrals." Plans must have a mechanism to prevent excess deferrals from being made in the first place or a procedure for distributing excess deferrals no later than the April 15 following the year in which they were made. Plans of related businesses that fail to distribute excess deferrals by April 15 can correct that qualification failure under the IRS's Employee Plans Compliance Resolution System (EPCRS) but, as discussed below, the failure to distribute by April 15 results in double taxation to the participant.

==> Double Taxation to Participant for Failure to Distribute by April 15. If a participant's excess deferral is not distributed by April 15, it triggers double taxation--a result that cannot be remedied under EPCRS. The excess deferral is taxed in the year it is withheld from the participant's pay (because it is not made on a pre-tax basis), and it is taxed again in the year it is distributed from the plan. In addition, the distribution may be subject to a 10% early distribution penalty if the participant is under age 59-1/2, unless an exception applies.

As we noted earlier, if excess deferrals arise because an employee participates in more than one plan of unrelated employers, the employee, not the employers, must monitor the annual deferral limit and request a timely distribution of any excess deferral (and the affected plans would not have incurred qualification errors).

For more information, see EBIA's 401(k) Plans manual at Sections IX.P.2 ("Dollar Limit on Elective Deferrals--Code Section 402(g)"), XIII.A ("Controlled Group and Affiliated Service Group Rules--Treating Multiple Employers as a Single Employer"), and XXXV ("Correcting Plan Mistakes: IRS's EPCRS").

Contributing Editors: EBIA Staff.

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