

Quarterly Review

Vol XVIII; Number 2

July, 2008

From the Desk of the Editor

Well the Grab Bag has arrived and luckily prior to the August Employer's Council on Flexible Compensation (ECFC) Conference. Muriel Etienne is attending the conference and we may have more information to share about the Grab Bag when she returns. Until then, our featured article this issue includes some of what we consider the more interesting answers to various questions posed in the guidance.

Two more states have issued health reform legislation geared toward improving the plights of their uninsured or underinsured residents. Both have extended health coverage to resident's adult children if they meet certain criteria. Since an adult aged 30 can be considered a dependent, we include a discussion about the tax issues under Café plans when a state's or health plan's definition of dependent does not *jive* with WFTRA's definition.

Two new contributors have excellent articles on ways to contain and manage health costs; see Barbara Gonzales' article on page 4, and Vince Pass' article on page 7.

This is our third year of including articles in this newsletter from past EBIA Weeklies. I select articles that are relevant to our plan offerings that I believe provide good information to our clients. This quarter you will find good articles on transportation programs, COBRA, 401(k) plans, Wellness, HSA comparability rules and the final regs on "who gets to claim the kids."

In addition, I like to include articles that describe and comment on recent case law. Case law helps set precedent for how regulators and courts will rule on similar matters. I have included three court cases involving the use of "discretionary" language. As plan sponsors or administrators we want discretion in determining plan provisions; however, that discretion doesn't always make courts or state regulators warm and fuzzy.

Finally, I asked our Chief Information Officer, Chet Hall, who is in my mind the epitome of a change agent to write a short piece on the subject. I am the compliance officer and I tend to like structure and sameness so I could never do such an article justice. Thanks Chet for a good shot in the arm - I suspect that 2009 will usher in change. Some welcome, some challenging, some change.

Trish Neely

In this Issue:

Feature Article: HSA Grab Bag Issued	1
HEART Act causes Heartburn	2
Tax Refunds Build HSAs	3
Health Care Trends.....	4
Self Funded Models Decrease Costs	4
Cover Florida w/ Health Care	5
NJ FamilyCare Legislation	7
Population Health Management – New Paradigm ..	7
Road to Change: Path of Least Resistance	8
Guest Articles	9

Feature Article

HSA Grab Bag Issued

Trish Neely, CFCI

On June 25th the long-awaited and much-anticipated grab bag of guidance on Health Savings Accounts was issued by the IRS. The guidance was prepared in a user-friendly Q&A format containing 42 questions under seven category headings. The guidance addresses:

- § Who is an Eligible Individual;
- § Issues related to High Deductible Health Plans;
- § Contributions to HSAs;
- § Distributions from HSAs; and
- § Establishing an HSA.

Keep in mind, the guidance is still new and it will take some time to fully flush out the high points or the hot spots. However, as a general comment, we have not seen anything really surprising in the guidance. Before we hit the highlights, some definitions will make reading easier:

§223(c)(3) Permitted Insurance or Coverage

includes: dental, vision, long term care, specified disease or illness coverages (i.e. cancer), disability, AD&D, and Archer MSAs.

§223(c)(2)(c) Preventive Care includes:

- § periodic health evaluations including tests and diagnostic procedures order in conjunction with an annual physical;
- § routine pre-natal and well-child care;
- § immunizations
- § tobacco cessation and obesity weight-loss programs;
- § screening devices and tests

Quarterly Review

Vol XVIII; Number 2

July, 2008

Now the highlights:

Participation in a limited purpose HRA that pays expenses for vision care, dental care and preventive in addition to the employee's share of HDHP premium payments is **not** a disqualifier to participating in an HSA.

A mini-med plan used to fill in gaps before the minimum HDHP deductible is satisfied is **not** a disqualifier as long as treatment is preventive or the coverage falls into the permitted category.

Employer payment or reimbursement of expenses below the HDHP deductible is **not** a disqualifier as long as the expenses paid relate to preventive or permitted coverage expenses.

Medicare is **not** a disqualifier to an HSA as long as an otherwise eligible individual is **not enrolled** in Medicare.

When an account holder turns 65, premiums for Medicare are qualified for payment through an HSA.

COBRA premiums for a spouse or dependent of an account holder are qualified for payment through an HSA.

Free or inexpensive healthcare provided at an onsite employer clinic is **not** a disqualifier as long as the clinic does not provide significant medical care.

An individual may rollover an existing HSA to a new HSA even if he/she is no longer eligible. (This is not surprising, but certainly nice to have in writing.)

Employer contributions including pre-tax salary reductions may be made up until April 15th for a prior year (assuming the financial institution can accommodate this).

Correcting errors

1) If an employee was never eligible under §223(c) then no "HSA" ever existed and the employer may correct the error.

2) An employer may correct an error involving a contribution that exceeds the maximum contribution permitted under §223(b).

In either of these cases, the Employer may either request return of money (less admin fees) from the financial institution or recharacterized the amount as taxable wages to the employee.

HSAs may be administered through an electronic payment card program as long as other options are also available to an individual to withdraw funds.

(A moot issue if Congress tightens its grip on what can

be reimbursed through an HSA and limits the account to medical expenses under code Section 213(d).)

An account holder may not borrow from his/her HSA or use the HSA as security for a loan.

An HSA is considered "established" through States' trust laws. So, if state law requires the account to be funded to be established so be it; or if state law requires a signature, so be it. If state trust law has other requirements they must also be met in order for the account to be considered established. It is the official "establishment" date that is used to determine when qualified medical expense may be reimbursed tax-free. One standard (rather than state by state standards) would have made things easier to explain and to administer.

HSA administration and maintenance fees are not distributions from the HSA, instead they are reflected on Form 5498-SA in the fair market value of the HSA at the end of the taxable year.

For a copy of the press release and the complete text log on to www.treas.gov/press/releases/hp1056.htm

HEART Act Causes Heartburn

Muriel Etienne
Trish Neely, CFCI

This is a very well meaning Act that leaves much to be desired and too much to be interpreted. Many of you have asked questions regarding implementation and unfortunately as we write this article, we know just a smidgeon more than we knew when we issued the recent Benefits Alerts on this topic. However, two teleconferences later, we will share what we know.

In case you missed the two previous Benefits Alerts, we will recap as we go along. The Heroes Earning Assistance and Relief Tax (HEART) Act makes changes to some of the rules governing 1) health flexible spending arrangements (HFSA), 2) Café Plans, and 3) other non-health benefits. We've separated the discussion into the three different parts and we are focusing on the key issues from the first two.

Part One. To help military personnel called to active duty, plan sponsors **may** make a cash distribution of unused HFSA benefits to eligible reservists without disqualifying their cafeteria plans. The distribution, which the Act refers to as **qualified reservist distributions (QRD)** is completely voluntary. If a plan sponsor decides to offer this, amendments must be made to existing plan documents. (We now have an amendment and SMM prepared for your use when you are ready.)

Quarterly Review

Vol XVIII; Number 2

July, 2008

In order for the distribution to be **qualified**, four things must occur:

- 1) The individual must be a "reservist" who is
- 2) Called to active duty for 180 days or an indefinite period.

-good so far but then things get interesting-

- 3) The distribution must be for all or a portion of the balance in the employee's account; and
- 4) The distribution must be made between *the date the reservist is called and the last day the reimbursement could be made for the plan.*

Two of the four items are troublesome. First, does "**all or a portion of the balance in the employee's account**" refer to how much the employee contributed less any reimbursements **or** how much is **available** under the uniform coverage rule? The Act does not make this clear. And second, we would interpret the timeline for distribution to mean the date of deployment through the runout period. However, the Joint Committee on Taxation's (JCT) technical explanation interprets the timeline differently. Again the Act does not make it clear.

Also unstated is the proper tax treatment of the distribution. It would make sense that it would be reported on the reservists W-2, but the Act is silent on this issue.

Without further guidance on two of the four requirements to have a Qualified Reservist Distribution, a conservative approach is to wait for further IRS guidance before proceeding.

However, one group of experts we have corresponded with have opined that since adoption is permissive meaning it's up to the plan sponsors, they (plan sponsors) should be able to use either interpretation. We have written the amendment in such a way that a plan sponsor may make the decision and amend the plan accordingly.

In anticipation of clients wanting to offer this feature, we have discussed internally how we will handle **QRDs**. The simplest approach is to receive notification from the employer/client that a reservist has been called to active duty, meets the criteria and requests a distribution. We will cut the check to the reservist and will notify the employer of the amount for purposes of preparing its W-2 Statements.

Part Two. The Act has a mandatory requirement to treat differential pay as wages for certain withholding and retirement plan purposes. At issue is whether differential pay may be treated as compensation for §125 "salary reduction" purposes and provide a mechanism to keep the café plan alive for the family.

Without further guidance a conservative approach is to wait for further IRS guidance before treating differential pay in a tax-favored manner.

However, an ECFC teleconference speaker opined that although the Act is unclear, it likely will allow salary reduction for cafeteria plan purposes. Further, the requirement to treat such pay as wages for "withholding" purposes is written broadly enough to allow pre-tax treatment.

Part Three. The Act makes other changes to non-health employee benefit plans which do not fall under the services we provide and are mentioned for information only, including:

1. A requirement that survivors of reservists who die while deployed receive the same additional benefits that would be received if the reservist was actively employed
2. A requirement to treat differential pay as compensation for retirement plan purposes
3. A permanent extension to the 10% early withdrawal tax exception for qualified reservist distributions

Expect this to generate some questions and hopefully answers from IRS officials at next week's ECFC conference. We will keep you informed as we learn more.

Tax Refunds Build Health Savings Accounts

Murielle Etienne

Tax refunds can be deposited directly into certain tax-favored accounts and provide a mechanism to build savings in the current tax year. Besides a direct deposit into a checking or savings account, tax payers may also direct their tax refund deposits into an individual retirement arrangement (IRA), health savings account (HSA), Archer MSA, or Coverdell education savings account (ESA). The refund can be split among up to 3 separate accounts simply by completing an IRS Form 8888 when filing taxes. Any amounts deposited directly into the tax-favored accounts will count toward any contribution limits and will be subject to all applicable taxes, including any penalties resulting from excess contributions that are not corrected in a timely manner.

What, you didn't mean for that stimulus payment to be deposited in a tax-favored account? The IRS announced on April 30, 2008 that taxpayers who had not intended to have their 2008 Economic Stimulus Payments directly deposited into a tax-favored account would be permitted to withdraw the amount free from taxes or penalties which would typically apply to amounts removed from these accounts. This relief is

Quarterly Review

Vol XVIII; Number 2

July, 2008

limited to the Economic Stimulus Payment only; amounts withdrawn from these tax-favored accounts can be less than or equal to a taxpayer's directly deposited stimulus payment. To qualify for this relief, funds must be taken out by April 15, 2009 for most taxpayers or Oct. 15, 2009 for those who obtain tax-filing extensions.

For more information please visit <http://www.irs.gov/pub/irs-drop/a-08-44.pdf>, and <http://www.irs.gov/pub/irs-pdf/f8888.pdf>.

Health Care Trends

Self-Funded Models Show Decreases in Medical Costs

Barbara L. Gonzales, CEBS

Editor's Note: *Barbara is the former Director for the State of Florida group insurance program and currently oversees FBMC's self-funded benefits division in Ormond Beach, Florida. She brings nearly 30 years experience with large group health plans, including the self-funding model for large plans.*

It's the time of year when employers with January 1 plan year dates for group health plans start pulling out calculators to take a serious look at plan costs. For many, if not most, the greatest concern is, "what will it cost to deliver health insurance in 2009 and how will that impact my ability to provide greater earnings to my employees".

A 2007 Kaiser survey shows some interesting trends in funding arrangements. **During a nine-year period (1999-2007), increases in health insurance premiums for fully insured health plans exceeded increases in premiums for self-funded plans.** For example, the differential varies by more than 3.2% in 2003 and by 1.9% in 2006.¹ Moderate savings, but certainly worthy of attention. Particularly when one considers that health insurance increases still continue to outpace workers' earnings and overall inflation in our country despite a recent slow down in those increases.

For all plan types, the average annual premium for single coverage in 2007 was \$4,479 and \$12,106 for family coverage. During 2007, premiums increased an average of 6.1% for employer-sponsored health insurance blowing by growth in workers' earnings of 3.7% and overall inflation increase of 2.6%. By plan type, HMO plans saw the greatest percentage increase at 8.3% with PPO plans trailing at 5.3%.¹

And, increases in overall medical costs vary depending on which part of the country you are domiciled. Medical costs vary from low to high by more than 25%. This geographic variation in medical costs as a percent of the national average is significantly higher in the northeast as compared to the southeastern, northwestern, and southwestern states.²

Region	Medical costs as a Percent of National average
New York	114.1%
Washington, DC	101.3%
Atlanta	96.7%
Chicago	106.3%
Dallas	99.6%
Seattle	91.1%
Los Angeles	99.1%

More than 86% of workers in large firms (5,000 or more employees) are covered by self-funded plans and more than 76% of workers in firms with 1,000 – 4,999 employees are in self-funded plans. Even firms with 200 – 999 workers look to the self-funding model for their employee health care needs.

If you are not familiar with a self-funded arrangement, it is a model for health care funding whereby the employer assumes direct financial responsibility (either through an insurance trust fund or its general assets) for the costs of its employees' medical claims. Individual stop-loss insurance can be purchased to protect the employer against a large loss on any one individual claim and if appropriate, aggregate stop-loss insurance can be purchased to protect the plan against losses exceeding an aggregate attachment point established by an underwriter. Thus, the employer can cap its risk for both individual and plan losses.

Self-funded plans are exempt from state insurance laws, reserve requirements, mandated benefits, and premium taxes. Essentially, the employer determines what is covered by the plan and what is not covered by the plan and this is memorialized in a plan document and summary plan description.

As you evaluate premium costs for the upcoming 2009 plan year, don't forget to take a look at the self-funded arrangement if you are not already using this successful model for funding your employees' health care costs.

For additional information please contact bgonzales@fbmc.com

1. 2007 Employer Health Benefits Annual Survey by The Kaiser Family Foundation and Health Research and Educational Trust
2. 2007 Milliman Medical Index

Cover Florida with Health Care

Story within a Story: Aged 30 “Dependents”

Trish Neely, CFCI

With a flourish of his pen in May 2008 Gov. Charlie Crist signed into law significant legislation relating to health insurance, placing Florida in the ranks of New Jersey (see separate article in this newsletter), New York, Massachusetts, Maine, Kentucky, California and numerous other states keen on the passage of health care reform and tired of waiting on Congress. Florida's new Act is intended to provide access to affordable health insurance to the state's growing uninsured and underinsured populations.

► The **Cover Florida Health Care Access Program**, which will be administered jointly by the Office of Insurance Regulation and the Agency for Health Care Administration, will include an affordable health care product for state residents that emphasizes coverage for basic and preventive health care services as well as inpatient hospital, urgent and emergency care services.

Plans must be offered on a guaranteed-issue basis, be portable and provide for cost containment through service limits and caps on benefit payments and co-payments. Eligible coverages will be administered on a pre-tax basis to increase savings. Consumer choice is provided through alternative benefit plan models having different cost and benefit levels, with at least one plan providing catastrophic coverage. Eligibility extends to state residents who are aged 19 to 64 (inclusively), have a family income equal to or less than 300% of the federal poverty level and are not covered by private insurance or eligible for coverage through a public insurance program.

► The **Florida Health Choices Program**, administered by a newly formed corporation, Florida Health Choices, Inc. is created as a single, centralized market for the sale and purchase of various products and services over the internet or through the services of a participating health insurance agent. Eligibility to participate includes small employer groups (1 to 50 employees), municipalities with fewer than 50,000 residents, fiscally constrained counties and school districts, rural hospitals, state employees not eligible for state health benefits and state retirees. The products will include health insurance plans, HMO plans, prepaid services, and flexible spending arrangements. The “corporation” will recruit and certify vendors and provide data monitoring and assessment for individuals and employers, in addition to performing administrative tasks generally associated with a benefits administrator.

The corporation will pool the risk of individual participants and prevent selection bias.

► The legislation modifies existing legislation. Florida Statute §409.814(5) was amended to remove the agency cap on the number of children eligible to enroll in the **Florida Kidcare & MediKids Programs**. Otherwise the programs are the same: a child who has not reached the age of 19 and whose family income is equal to or below 200% of the federal poverty level is eligible for the Kidcare Program; a child whose family income is above the 200% of the federal poverty level is eligible to participate in the Florida Medikids program.

► Florida Statute §627.602(c)(1) was amended such that an **adult “child” aged 30 may be deemed a dependent** for purposes of “**health**” insurance eligibility and access. It is important to note, that the amendment does not apply to accident only, specified disease, disability income, Medicare supplement, or long-term care insurance policies. Here is how it will work:

If an insurer offers coverage under a group, blanket, or franchise health insurance policy that insures dependent children of the policyholder, the policy **must** insure a dependent child until the end of the calendar year in which the child reaches the age of 30 if the child:

- § Is unmarried and does not have a dependent of his or her own;
- § Is a resident of Florida or a full-time or part-time student; and
- § Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

Currently the statute includes a similar requirement for a child who reaches the age of 25; effective for policies issued or renewed on or after 10/1/2008, the new language applies as well.

Administratively, this could cause some initial heartburn as insurers and employers modify communication materials and certificates of coverage; and revise procedural controls and any systemic edit checks in place to monitor dependents' ages.

Fortunately, the amendment made provisions for dependents who “aged-out” under the health plan's current terms but come October will be eligible again. The parent(s) of a dependent child who falls into this category have until April 1, 2009, to make a written election to reinstate coverage, without proof of insurability. A Notice regarding the reinstatement of coverage for a dependent child must be provided to a covered person in the certificate of coverage prepared by the insurer or the covered person's employer.

Quarterly Review

Vol XVIII; Number 2

July, 2008

Another area to watch carefully is **implementing the state's requirement within a §125 Café Plan**. Just as many of us discovered when we extended health coverages to our employees' domestic partners, state law does not preempt federal law when it comes to the definition of dependent. For **§125** purposes we must look to the Working Families Tax Relief Act (WFTRA) for guidance. A **qualifying child under WFTRA has an age limit of 19 or 24 if a full-time student**. So our dependents under the new State requirement would need to meet the WFTRA definition of **qualifying relative** in order for the premiums to be eligible for tax-favored treatment under the Café Plan. Probably not that difficult to do, but it is an exercise that the employer and the employee must go through when determining the correct tax treatment of the dependent's premium. At the end of this article, I have included WFTRA's definition of dependent for purposes of federal tax law.

The new legislation does not affect or preempt an insurer's right to medically underwrite or charge the appropriate premium, nor does it require an employer to pay all or any part of the cost of coverage provided for a dependent under the new section. In addition, the amendment does not require a health policy to offer dependent coverage. But if it does, the policy must comply with the provisions of §627.6562 FI Stat. We have already communicated with our preferred providers so that they are prepared to comply with the requirements of the legislation.

A few challenges I see ahead:

§ If the dependent does not meet the federal definition of dependent then the employer can either run that portion of the premium on a post-tax basis, or impute the income of the tax payor at year end.

§ Loss of coverage is a valid mid-year change in status event; however **gaining** coverage is not. Although the legislation gives parents until April 2009 to reinstate a child (and health plans must comply), the child must be reinstated during open enrollment to receive favored tax treatment under the Café Plan. If he/she is added mid-plan year, same solution as above - the employer can either run that portion of the premium on a post-tax basis, or impute the income of the tax payor at year end.

§ I expect more parents to request to drop dependents due to the lifting of enrollment caps on the Florida Kidcare and Medikid programs. However, there will be some disappointments.

After a **§125** plan year begins the participant generally cannot **stop** salary reducing his/her

dependent's pre-tax health premiums. The 2001 final regulations **only** recognize a **loss** of health coverage under a governmental /educational institution plan, not the gaining of eligibility for health coverage under such a plan.

However, if the parent is requesting to drop dependent coverage due to the dependent gaining eligibility for **Medicare/Medicaid** that is a different story. If the dependent becomes eligible for and enrolls in Medicaid through Florida's Kid Care Medicaid program, the change will be granted as a valid change in status event.

Although I have tried to anticipate your questions and concerns, please contact tnelly@fbmc.com for any additional inquiries you may have.

For a full text of the Act visit www.laws.flrules.org/files/ch_2008-032.pdf

Working Families Tax Relief Act

Qualifying Relative:

Relationship. The QR group is broader than the QC group. QR must have specified familial-type relationship to the taxpayer:

- Ø son/daughter, half-brother/sister, stepchild, sibling/stepsibling, or a descendant of any such individual (grand/great grandchild, nieces/nephews, step-nieces/nephews, etc.).
- Ø legally adopted child, or a child lawfully placed with the taxpayer for legal adoption.
- Ø foster child placed with the taxpayer by an authorized placement agency or by judgment, decree, or court order.
- Ø parent (or an ancestor of either), stepparent, aunt/uncle, first cousin.
- Ø certain in-laws (son-, daughter-, father, mother-, sister- and brother).

Or

Ø any other individual (other than the spouse) but only if the relationship does not violate local law.

Ø QR cannot be anyone's QC.

Ø As before WFTRA, a child of divorced parents is treated as a dependent of both parents if certain requirements in Code § 152(e) are met.

IRS Notice 2004-79 Permitted Exceptions:

- Ø Anyone who would be a taxpayer's QR *but for the fact that the taxpayer is a Code § 152 dependent of a parent or other person.*
- Ø Anyone who would be a taxpayer's QR *but for the fact that s/he files a joint return with his/her spouse.*

Quarterly Review

Vol XVIII; Number 2

July, 2008

Residency

- Ø No residency requirement for individual having above specified familial-type relationship to the taxpayer.
- Ø Persons not having one of above familial-type relationships with taxpayer must have the same principal place of abode as the taxpayer for the tax year, and be a member of the taxpayer's household.
- Ø As before WFTRA, a QR must be a citizen or resident of the U.S., or resident of Canada or Mexico (there's an exception for adopted children).

Specified Age. None.

Support. QR must receive over half of their support from the taxpayer for the tax year.

Qualifying Child (partially included for reference only)

Specified Age. QCs must not have attained age **19** (age **24** if a full-time student) as of the close of the calendar year in which the taxpayer's taxable year begins. Subsequent to WFTRA, a "too old" child cannot be treated as the taxpayer's QC, unless the child is permanently and totally disabled at any time during the calendar year in which the child turns the limiting age without regard to whether the child is a student or not.

New Jersey Progressive FamilyCare Legislation

Muriel Etienne

On July 7, 2008 the Governor of New Jersey, Jon S. Corzine signed the "Progressive FamilyCare Legislation" bill which expands New Jersey's FamilyCare legislation and establishes mandates for health care coverage of all children. The bill initiates a number of reforms to individual and small employer insurance markets. **And** like Florida (see previous article) has an age of dependency beyond the typical age 19 or 24 (if certain conditions are met.) Although the bill is new enough that we have not had an opportunity to analyze completely, some of the highlights related to the dependency issue include:

Dependent Coverage for Dependents 30 Years of Age or Younger Reforms:

- § Amends the eligibility terms, requirements and administration of continued dependent coverage for dependents 30 years of age or younger.
- § Requires evidence of past, creditable health benefits coverage or acknowledgment of benefits from a different group or individual benefits coverage source to be eligible to elect or reinstate continued dependent coverage.

- § Once an individual elects dependent coverage, that coverage is not defunct until the individual attains the age of 31. The cut off for electing coverage remains 30 years of age; the bill **clarifies** that the dependent coverage remains in effect while the individual is 30 years of age.
- § Health insurers and the State Health Benefits Program (SHBP) must provide notice to the parents of dependents to boost consciousness of continued dependent coverage.

We have the same concerns as identified with Florida's recent legislation regarding **implementing the state's requirement within a \$125 Café Plan**. Dependents under the State requirement must meet the WFTRA definition of **qualifying relative** in order for the premiums to be eligible for tax-favored treatment under the Café Plan.

To review bill S1557/A2624 visit:

http://www.njleg.state.nj.us/2008/Bills/S2000/1557_R3.HTM

Wellness to "Population Health Management" – A Paradigm Shift

Vincente Pass

Editor's Note. *Vince is FBMC's Partner Relationship Manager for our self-funded benefits division. He manages the relationship with Stop Loss, Pharmacy Benefit Management, Medical Management, PPO's, and Value Added Services partners.*

Population health management goes beyond traditional "wellness care," it is a **clinically-based preventive care process that stresses early detection, testing and aggressive follow-up of company employees before health problems take hold.** [From a recent Business Wire press release.]

When you consider that the new generation of workers is the first generation to be less healthy than their parents, and when you listen to experts predict that employers will become more involved in health care as a result, you get a sense for how population health management comes into play.

We are well aware of the increasing pressure our clients face in the areas of budget and cost containment – as an employer we face it as well. For these very reasons FBMC has negotiated an exclusive partnership with one of Forbes 200 best small companies. The company presents a population health management solution that includes turnkey programs that are clinically based and fully HIPAA compliant. We have conducted a thorough due diligence and are very impressed with their program.

Quarterly Review

Vol XVIII; Number 2

July, 2008

A recent report the company has issued states, “As many as 58 percent of employees have medical conditions that are unknown and/or not being treated, and require some type of medical intervention.” As an approach, population health management does not just focus on defined health risks within an employer group; it is used to keep healthy employees healthy. Each employee is provided with a customized course of action which increases their overall health in the majority of cases. Medical resources such as in-person health courses and online information about specific conditions are made available to each employee who participates in the program. Health evaluations are held on-site at all employer locations by trained medical professionals.

It makes sense that healthier employees incur less healthcare costs and we have seen statistics which demonstrate that companies who have embraced a population health management approach have seen savings of as much as \$2,850 per employee per year, and a medical cost growth rate of 54% less than average companies.

The positive impact of a population health management program for employees is a happier and healthier working environment with employees that live longer and more productive lives. For the employer the program translates into greater productivity from the workforce in addition to being an effective tool for reducing healthcare costs.

For additional information on how your organization can benefit from a population health management solution without any additional direct cost to your existing medical plan please contact me at vpass@fbmc.com.

The Road to Change is The Path of Least Resistance

Chet Hall, CIO

Over the years I have read many articles on Change Management and I still have not figured out why “Change” is such a dirty word, other than that’s what all the articles say.

Not only do I disagree, I am going to tell you how much I like change and why you should too.

I like change for the simple reason that it’s how we grow and improve everyday. Being in the business and technology field for so long I guess that I have just come to the conclusion that

change is a fact of life. And I want to grow and improve everyday. Isn’t growing and improving the American way?

Change happens everyday in every form of business whether we want it to or not. Change almost always creeps upon us in positive ways but I think it’s human nature to focus on the negative and ignore the positive side. Take the evening news – reporters focus on the negative things while the positive human interest stories are set aside. But think about it for a minute ... In my opinion, most change that occurs in life is positive. For example, my daughter calls to tell me she made the dance team or my son sends me a text message that he is now taller than is older sister.

In business it is the same way. Like the other day when a project team deployed a new process improvement initiative. Rock on!

Many years ago I was hired to work as an information analyst in the automotive industry. The person that hired me warned me that things “happen and change fast around here.” I proudly told him I was ready for the job. A few weeks after I had been working there he asked me how I was adapting. I told him that I heard him when he said that things moved fast but I did not realize that he was asking me to jump on a **moving bullet train** while I was standing at the train station.

Just like the bullet train leaving the station we all tend to look at change as if we will miss the jump only to crash and burn – this is what makes change frightening for some. But reality is that we are more likely to “crash and burn” so to speak if we **don’t** jump on. In the business world, you can bet the competition is jumping aboard.

The secret to change is to use our knowledge and experience to **just do it**. The more we practice jumping, the more skilled we will become.

If you are working on change initiatives in your organization, focus on the positive aspects of change – change can be powerful, change can revolutionize. In the long run, the road to change **is** the path of least resistance.

GUEST ARTICLES

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IRS ISSUES FINAL REGULATIONS ON TAX EXEMPTION FOR CHILDREN WHOSE PARENTS ARE DIVORCED, SEPARATED, OR LIVING APART

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[Treas. Reg. Sec. 1.152-4, 73 Fed. Reg. 37797 (July 2, 2008)] For a copy: <http://edocket.access.gpo.gov/2008/pdf/E8-15044.pdf>

The IRS has issued final regulations regarding when parents who are divorced, separated, or living apart are entitled to claim a child as a dependent. The final regulations, which apply to taxable years beginning after July 2, 2008, reflect changes to the definition of dependent in Code Section 152 that were made by WFTRA and subsequent legislation. By way of background, a taxpayer generally may only claim a dependency exemption for a child who is the taxpayer's "qualifying child" or "qualifying relative" under Code Section 152. However, Code Section 152(e) provides a special rule for children whose parents are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or live apart at all times during the last six months of the calendar year. Under the special rule, the child is treated as the qualifying child or qualifying relative of the noncustodial parent if these three requirements are met: (1) over half of the child's support during the year is from one or both parents; (2) the child is in the custody of one or both parents for more than half of the year; and (3) the custodial parent signs a written declaration that he or she will not claim the child as a dependent, which the noncustodial parent attaches to his or her tax return.

The final regulations provide additional guidance and clarifications regarding the special rule, and reflect a number of revisions to the proposed regulations that were issued in 2007 (see our article at <http://www.ebia.com/WeeklyArchives/CafeteriaPlans/Statutes/19003> (Premium Access subscription required)). For example,

the final regulations define the term "custody," clarify the "counting nights" rule that is used to identify the custodial parent when both parents have custody, and include many more examples. The final regulations also note that if the special rule of Code Section 152(e) applies, then the child is treated as a dependent of both parents for purposes of the tax exclusions for health coverage in Code Sections 105 and 213 and for certain fringe benefit purposes under Code Section 132. The preamble to the regulations further provides that if a custodial parent does not release the claim to the exemption, then only the individual who is entitled to claim the child as a dependent may treat the child as a dependent for purposes of these Code provisions.

EBIA Comment: The final regulations replace regulations that are over 20 years old (and, in many instances, obsolete). Employers should know about these rules because, generally, coverage under a cafeteria plan can only be provided for someone who is a participant, the participant's spouse, or a tax dependent. (DCAP administrators should keep in mind that the rules for DCAPs are different from the rules for health coverage described in Code Sections 105 and 213; only a custodial parent may take the DCAP exclusion.) Likewise, the Code's fringe benefit rules treat use of certain fringe benefits by an employee's spouse or dependent child as use by the employee. For more information, see EBIA's Cafeteria Plans manual at Sections XI.D.5 ("Two Special Rules for Divorced or Separated Parents") and XXIV.G.1.b ("Special Rule for Certain Parents Who Are Divorced, Separated, or Living Apart"); see also EBIA's Consumer-Driven Health Care manual at Sections XV.C ("What Is an HSA Qualified Medical Expense?") and XXII.C.2 ("HRAs: Who Is a Dependent?"); and EBIA's Fringe Benefits manual at Section XI.C.1 ("Qualified Employee Discount Programs: Key Terms: Employees").

Contributing Editors: EBIA Staff.

STATE LAW PLACING LIMITS ON DISCRETIONARY LANGUAGE IN INSURANCE POLICIES FOUND TO BE PREEMPTED BY ERISA

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[[Weeks v. Unum Group, 2008 WL 2224832 \(D. Utah 2008\)](#)]

For a copy: https://ecf.utd.uscourts.gov/cgi-bin/show_public_doc?2007cv0577-66

Does ERISA block the enforcement of state laws that restrict "discretionary" language in insurance policies issued under ERISA plans? (Discretionary language reserves discretion to interpret the plan and is required

Quarterly Review

Vol XVIII; Number 2

July, 2008

for an insurer to receive a more favorable standard of review when benefit denials go to court.) Two cases we reported on recently found that such laws were not blocked from enforcement by ERISA because they qualified as laws regulating insurance and were therefore "saved" from preemption under ERISA Section 514. (See our article at <http://www.ebia.com/WeeklyArchives/ERISA/CourtCases/19328> (Premium Access subscription required).) In this case, the court considered a Utah regulation that required discretionary language in insurance policies to be explicit, conspicuous, and follow specific model language. The ERISA plan participant in the case (whose disability benefits had been terminated by the insurer) argued that the insurance policy's discretionary language should not be given effect because it did not comply with the state law. Acknowledging that the language did not comply, the insurer argued that the state law was irrelevant because it did not qualify as a law regulating insurance and was, therefore, preempted by ERISA.

In considering the question, the court noted its agreement with the earlier courts that had found similar laws to be enforceable because they were saved from ERISA preemption as laws regulating insurance. However, unlike the laws in the earlier cases, the Utah law in this case did not prohibit discretionary language outright, but only dictated its form and content. This was crucial to the court, which held that under controlling Supreme Court precedent, the Utah law did not substantially affect the relationship between the insurer and the insured enough to qualify as a law regulating insurance. As a result, unlike the previously considered laws, the Utah law was not saved from ERISA preemption. The law was therefore unenforceable, and the insurer's discretionary language was to be given effect for purposes of what standard of review to apply.

EBIA Comment: The issue in this case has practical significance because, if ERISA preemption makes this kind of state law unenforceable, affected insurers will be free to include discretionary language that would otherwise be precluded. As a result, benefit denials will, in general, be subject to a more favorable standard of judicial review when challenged in court, making them more likely to be upheld. Of course, even when the more favorable standard of review applies, a conflict of interest on the insurer's part can alter the standard under the test articulated by the U.S. Supreme Court in its most recent ERISA decision. (See our article at <http://www.ebia.com/WeeklyArchives/ERISA/CourtCases/19423> (Premium Access subscription required).) It remains to be seen how this new test will be applied by the courts in the future. For more information, see EBIA's ERISA Compliance manual at Sections XXXIX.D ("Certain State Insurance Laws Are Saved From Preemption"), and XXXVI.C ("Standard of Judicial Review Applied to Plan Administrator's Decision").

Contributing Editors: EBIA Staff.

WHEN EMPLOYER IS ALSO PLAN ADMINISTRATOR, COBRA ELECTION NOTICE DEADLINE IS 44 DAYS AFTER EMPLOYEE'S TERMINATION

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[[Dougherty v. Blize, 2008 WL 2543430 \(D. Del. 2008\)](#)]

For a copy:

<http://www.ded.uscourts.gov/LPS/Opinions/Jun2008/07-674.pdf>

The employee in this case was placed on leave due to disputes about his work performance. Afterward, his employer refused to communicate with him regarding his employment status and failed to pay him for the period just before the leave began. Nevertheless, the employer paid for the employee's health insurance coverage for approximately four months and, a short time later, sent him a COBRA election notice indicating that he had been terminated four months after the leave started. The employee filed suit, alleging various employment law and other violations, including a claim that the COBRA notice was late, incomplete, and deceptive.

Addressing the COBRA timeliness claim, the court in this preliminary decision accepted the employer's allegation that it was also the plan administrator, and held that the employer had satisfied the 44-day time period applicable under the DOL's COBRA notice regulations when an employer is also plan administrator. As a result, the court entered judgment for the employer on the timeliness claim but reserved for further factual development the claim that the notice was incomplete and deceptive. (Among other things, the employee argued that the notice improperly failed to identify the nature of the qualifying event.)

EBIA Comment: The 44-day time period runs from the date of the qualifying event and applies only to the events of employee termination, reduction of hours, death or Medicare entitlement, and employer bankruptcy (i.e., events for which the employer is required to notify the plan administrator). The 44-day period combines the basic 30-day statutory period (for the employer's qualifying event notice to the plan administrator) with the basic 14-day period (for providing the election notice). Significantly, the rule applies to most COBRA plans since most employers are also the plan administrators for their plans. This is because most plans are sponsored by employers that are either single business entities or controlled groups, and such employers are, by definition, plan administrators unless some other person or entity is

designated. In addition, the result is the same even for employers that use third-party "administrators," unless the TPA has agreed to be the "plan administrator" for compliance purposes. (This is a point of frequent confusion.) Of course, to reduce adverse selection, it is advisable for election notices to be provided before the 44-day deadline. This, in turn, requires providing notice to those responsible for actually sending election notices (including TPAs) as soon as possible after these qualifying events occur. For more information, see EBIA's COBRA manual at Sections XVIII.C ("Plan Administrator Must Provide Election Notice and Notice of Unavailability") and XVIII.G ("When Must the Election Notice Be Sent?"); see also EBIA's ERISA Compliance manual at Section XXIX.B ("Who Is the ERISA Plan Administrator?").

Contributing Editors: EBIA Staff.

WHAT A DIFFERENCE A WORD MAKES: PLAN WITHOUT "DISCRETION" LANGUAGE LOSES APPEAL IN BENEFITS CASE

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[\[Woods v. Prudential Ins. Co., 528 F.3d 320 \(4th Cir. 2008\) and Gutta v. Standard Select Trust Ins. Plans, 2008 WL 2521662 \(7th Cir. 2008\)\]](#)

For a copy of Woods:

<http://pacer.ca4.uscourts.gov/opinion.pdf/071580.P.pdf>

For a copy of Gutta:

<http://www.ca7.uscourts.gov/fdocs/docs.fwx?caseno=06-3708&submit=showdkt&yr=&num=>

Two recent federal appeals court cases demonstrate that having the right language in the plan document often determines whether the plan wins or loses a benefits-denial case. In each case, the plan administrator denied a claim for disability benefits, the trial court upheld the plan's decision, and the participant appealed. In the Fourth Circuit case (Woods) the plan lost the appeal, while in the Seventh Circuit case (Gutta) the plan won. The Seventh Circuit noted, as is often the case, that the decision largely turned upon whether the plan document contained language giving the plan administrator discretion in determining benefits.

As background, the Supreme Court has held that the standard to be used by courts reviewing an ERISA benefits-denial case will be a strict one, in which the court substitutes its judgment for the administrator's, unless the plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. If the administrator is given discretionary authority, then the court will generally defer to the administrator's decision. In Woods, although the SPD explicitly stated that the administrator had discretion to interpret the plan, the

plan document simply provided that claimants were eligible for benefits "when [the administrator] determines" that eligibility exists. The Fourth Circuit concluded that although this language conferred authority to make benefit determinations, it did not create "discretionary" authority (i.e., wide discretion in exercising its authority and freedom from close scrutiny by a reviewing court). The court reasoned that concluding otherwise would erase the distinction between authority to determine eligibility for benefits (which an administrator always possesses) and discretionary authority. In contrast, the plan document in Gutta contained additional language giving the administrator "full and exclusive authority to control and manage . . . administer claims . . . interpret . . . and resolve all questions arising in [the policy's] administration, interpretation, and application," and added that "any decision [the administrator] makes in the exercise of [its] authority is conclusive and binding." This language led the court to review the plan administrator's decision deferentially and ultimately uphold the denial of benefits.

EBIA Comment: The moral of the story is to check your plan document to be sure it contains language that confers on the plan administrator discretionary authority to determine eligibility for benefits and construe the terms of the plan. For more information, see EBIA's ERISA Compliance manual at Sections XI.B ("Discretionary Authority to Interpret Plan and Determine Facts") and XXXVI.C ("Standard of Judicial Review Applied to Plan Administrator's Decision").

Contributing Editors: Thanks to attorney James D. O'Connell for his contributions to this article, with final editing by EBIA staff. Mr. O'Connell is a Partner in the law firm of Jacobs, Burns, Orlove, Stanton & Hernandez (www.jbosh.com), in Chicago, Illinois. He is a contributing author of EBIA's ERISA Compliance manual and a former contributing author of EBIA's HIPAA Portability, Privacy & Security manual.

FAILURE TO MEET TECHNICAL REQUIREMENTS AND TO TIMELY SUBMIT DIVORCE DECREE PREVENT RECOGNITION AS QDRO

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[\[R.A.F. v. Southern Co. Pension Plan, 2008 WL 2397391 \(M.D. Ala. 2008\)\]](#)

This case involved a divorce decree that was not submitted to the plan administrator until after the participant's death, which occurred more than two years after the divorce. The plan administrator found that the decree could not be a qualified domestic relations order (QDRO) because the assigned benefits were earned

Quarterly Review

Vol XVIII; Number 2

July, 2008

under a defined benefit plan and after the participant's death there was nothing left to assign. The plan administrator also concluded that the decree failed nearly every standard that an order must meet to be a QDRO. On review, the trial court affirmed the plan administrator's determination that the decree was not a QDRO. The decree did not identify the parties' addresses, specify the affected plan, or indicate what benefit percentage was to be paid. In this court's view, these technical failures were sufficient to prevent the divorce decree from being a QDRO. While the trial court did not accept the administrator's conclusion that there was nothing left to assign after the participant's death, it did find that the decree would fail to be a QDRO even if it satisfied the technical requirements for QDROs. The plan's QDRO procedures provided for the recognition of orders submitted after a participant's death only if there was insufficient time to obtain an order before the participant's death. The failure to submit the decree in the two years between the divorce and the participant's death failed to meet that standard. Other cases allowing orders to be issued after the participant's death were not analogous because in this case there was sufficient time to act and the delay was not caused by any clerical error.

EBIA Comment: Although this case did not involve a 401(k) plan, it raises two issues of significant interest to 401(k) plan sponsors and administrators. First, the case serves as a reminder that even though the DOL has suggested that perfect compliance with the QDRO technicalities is not necessary, those requirements cannot be ignored. For example, some courts overlook the technical requirement that the order state the parties' addresses, but in this case that failure was significant because the plan administrator did not have actual knowledge of the alternate payee's address. Second, the case highlights the important role that a plan's QDRO procedures can play in the QDRO review process. As this case shows, an explicit policy regarding the acceptance of orders after a participant's death may draw a line that the courts will enforce. We note, however, that QDRO procedures must now reflect new DOL regulations that address timing issues related to QDRO determinations (see our article at <http://www.ebia.com/WeeklyArchives/401k/Statutes/18933> (Premium Access subscription required)). For more information, see EBIA's 401(k) Plans manual at Sections XXIII.B.5 ("Post-Retirement and Post-Death QDROs"), XXIII.B.6 ("Timing and Order of Domestic Relations Orders"), and XXIII.D ("Plans Must Have Written QDRO Procedures").

Contributing Editors: EBIA Staff.

IRS PROPOSES REGULATIONS ON HSA COMPARABILITY REQUIREMENTS AND HSA AND GROUP HEALTH PLAN EXCISE TAX REPORTING

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[Prop. Treas. Reg. Secs. 54.4980B-2, 54.4980D-1, 54.4980E-1, 54.4980G-1, 54.4980G-3, 54.4980G-4, 54.4980G-6, and 54.4980G-7, 72 Fed. Reg. ___ (July 16, 2008)] For a copy: http://federalregister.gov/OFRUpload/OFRData/2008-16175_PI.pdf

The IRS has issued proposed regulations providing guidance on changes to the HSA comparability rules under the Tax Relief and Health Care Act of 2006 (TRHCA). (The comparability rules only apply to employer HSA contributions made outside of a cafeteria plan.) Among other things, the proposed rules address the special comparability rule that allows employers to contribute more to the HSAs of non-highly compensated employees, the "full-contribution rule" that allows maximum annual HSA contributions to be made for employees who become eligible individuals mid-year and remain eligible on December 1, and special comparability rules for qualified HSA distributions. In addition, the proposed regulations provide that the excise taxes under Code Sections 4980B (COBRA), 4980D (group health plan requirements, including HIPAA portability and mental health parity requirements), 4980E (Archer MSA comparability), and 4980G (HSA comparability) must be filed using Form 8928 ("Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code"). The proposed regulations also address timing requirements for filing Form 8928 and the corresponding excise tax payment.

The rules that provide guidance on employer comparable contributions are proposed to apply to contributions made on or after the first day of the first calendar year after final regulations are published. (However, taxpayers may rely on the guidance for employer contributions made on or after January 1, 2007.) The rules that provide guidance relating to excise taxes are proposed to be effective for calendar years (or plan years, where applicable) beginning after the date the final regulations are published. We will cover these proposed rules in detail in next week's EBIA Weekly.

Contributing Editors: EBIA Staff.

CMS OFFICIALS PROVIDE INFORMAL VIEWS ON HIPAA SECURITY ISSUES

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[ABA Joint Committee on Employee Benefits, Meeting with CMS Officials (May 5, 2008)] For a copy: <http://www.abanet.org/jceb/2008/CMS2008.pdf>

The Joint Committee on Employee Benefits (JCEB) of

Quarterly Review

Vol XVIII; Number 2

July, 2008

the American Bar Association has reported on its May 5, 2008 Q&A session with officials from the Centers for Medicare and Medicaid Services (CMS). The report includes the following informal, non-binding remarks regarding HIPAA security rule compliance issues:

==> Remote Use of Electronic Media: Q/A-6. CMS officials indicated that there are no plans at this time to amend the HIPAA security regulations to incorporate previously issued written guidance on remote use of electronic PHI (see our article at <http://www.ebia.com/WeeklyArchives/HIPAA/Statutes/18850> (Premium Access subscription required)). However, officials noted the importance of determining whether or not to adopt encryption standards for laptops that contain or can access PHI. If such standards are not adopted, the entity must implement a suitable alternative and document the reasons for its selection. It was also noted that employers, as sponsors of group health plans, are ultimately responsible for a data breach by a TPA or other business associate. Thus, there is an obligation on the part of the health plan to perform due diligence on the security measures adopted by a business associate and to ensure that contracts require TPAs to protect data.

==> HIPAA Security Audits: Q/A-7. CMS recently announced that a limited HIPAA security audit program has begun, with audits to be based on complaints received by CMS. JCEB representatives asked whether any group health plans were selected for an audit and whether any information could be shared regarding major violations that were discovered during an audit. Declining to disclose specific details regarding audit activities, CMS officials emphasized that the goal of the audits is not to impose monetary penalties (although penalties are always a possibility). Instead, the penalties assessed for noncompliance would depend in part upon the level of cooperation. Officials also mentioned that a major issue they have seen is the failure of covered entities to update their policies and procedures for changes in the security environment and the technological landscape. For example, there is more remote use of PHI because more employees now work in settings outside the office than was the case when the security regulations initially took effect. Thus, policies and procedures must be reviewed and updated to account for remote use of PHI.

EBIA Comment: Although the report indicates that none of the comments should be considered as official guidance, it provides helpful insight regarding the issues addressed. It is also a good reminder that group health plan sponsors should periodically review and update their HIPAA policies and procedures, and should address the security measures needed for the remote use of PHI. For more information, see EBIA's HIPAA Portability, Privacy & Security manual at Sections XXIX.B. ("What Information Is Protected and

What Entities Must Comply?") and XXI.D.4. ("Enforcement: HIPAA Compliance Audits by HHS").

Contributing Editors: EBIA Staff.

DOL ISSUES FAQs ON SCHEDULE C REPORTING FOR 2009 FORM 5500

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[DOL FAQs About the 2009 Form 5500 Schedule C]

For a copy of the FAQs:

http://www.dol.gov/ebsa/faqs/faq_scheduleC.html

For a copy of the News Release:

<http://www.dol.gov/ebsa/newsroom/ebsa071408.html>

The DOL has issued 40 frequently asked questions (FAQs) on Form 5500 Schedule C reporting for plan years beginning January 1, 2009. In November 2007, the DOL, IRS, and PBGC jointly issued final Form 5500 regulations and adopted final revisions to the Form 5500 that generally will be applicable for 2009 and later plan year filings (see our article at <http://www.ebia.com/WeeklyArchives/ERISA/Statutes/19210>

(Premium Access subscription required)). The FAQs provide guidance to plan administrators and service providers to assist in complying with the requirements of the 2009 Form 5500 Schedule C, including guidance on indirect and non-monetary compensation and electronic disclosure of fee information by service providers. We will cover this development in detail in next week's EBIA Weekly.

Contributing Editors: EBIA Staff.

QUESTIONS OF THE WEEK

QUESTION: Our Company has a qualified transportation fringe benefit plan under Code Section 132(f) that provides parking, transit pass and vanpooling benefits. Are we required to file a Form 5500 for this plan?

ANSWER: No. Form 5500 (Annual Return/Report of Employee Benefit Plan) is used to satisfy annual reporting obligations that arise under the Code or ERISA. While Code Section 6039D imposes an annual information return requirement on certain "specified fringe benefit plans," qualified transportation fringe benefit plans are not included. (The reporting obligation under Code Section 6039D did apply to cafeteria plans and certain other benefit plans but it has been suspended by the IRS--see our article at <http://www.ebia.com/WeeklyArchives/CafeteriaPlans/Statutes/16727> (Premium Access subscription required).)

Quarterly Review

Vol XVIII; Number 2

July, 2008

ERISA Section 103(a)(1)(A) imposes an annual reporting obligation on "employee benefit plans" within the meaning of ERISA, but that term only includes plans that are "employee welfare benefit plans" as defined by ERISA Section 3(1), "employee pension benefit plans" as defined by ERISA Section 3(2), or both. Since qualified transportation fringe benefit plans (which may only offer qualified parking, transit pass, or vanpooling benefits) do not fall under either category, they are not employee benefit plans subject to ERISA's annual reporting obligation.

Because neither the Code nor ERISA imposes an annual reporting requirement on qualified transportation fringe benefit plans, a Form 5500 is not required for these plans. For more information, see EBIA's Fringe Benefits manual at Sections III.Q ("Qualified Transportation

Plans: Are There Any Reporting and Disclosure Obligations?") and III.S ("What Laws (Other Than Code Section 132) Apply to Transportation Fringe Benefit Plans?").

Contributing Editors: EBIA Staff.

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QUESTION: For several years, our company's 401(k) plan has used the Code Section 401(k)(12) safe harbor to avoid performing the ADP and ACP nondiscrimination tests. We understand that there is a new safe harbor that requires automatic enrollment. Could you describe how the new safe harbor differs from the one that we are using?

ANSWER: A new safe harbor design, authorized by Code Section 401(k)(13), is available for plan years beginning on or after January 1, 2008. The new design is called a "qualified automatic contribution arrangement" (QACA) because it requires minimum automatic deferrals in addition to minimum employer matching or nonelective contributions. Like your existing safe harbor under Code Section 401(k)(12), the QACA safe harbor allows plans to avoid performing the ADP test only or both the ADP and ACP tests.

==> Automatic Deferral Feature. The feature that most distinguishes the QACA safe harbor from your existing safe harbor is that the QACA requires automatic deferrals to the account of any eligible employee who does not make an affirmative election to defer (or to decline deferrals). During the initial period (which can be up to two years after an employee's first automatic deferral), the automatic deferral percentage must be at least 3% of compensation. Thereafter, the automatic deferral percentage must increase at least 1% per year

until it reaches 6%. A QACA can provide for higher automatic deferral percentages, but the automatic deferral percentage cannot exceed 10% of compensation.

==> ADP Safe Harbor. Like your existing ADP safe harbor, the QACA's ADP safe harbor requires minimum matching or nonelective contributions for all eligible non-HCEs. (HCEs also can receive these contributions so long as the plan meets certain design requirements.) The nonelective formula is the same for both safe harbors, requiring nonelective contributions equal to at least 3% of compensation. The matching formulas, however, are different. The QACA's matching formula only requires plans to offer a 3.5% matching contribution, compared to the 4% that must be offered under your existing safe harbor. The QACA matching formula also allows plans to require higher deferrals to receive the full matching contribution. Under the QACA formula, matching contributions must equal 100% of deferrals up to 1% of compensation plus 50% of deferrals that exceed 1% but do not exceed 6% of compensation. Under your existing safe harbor, the required matching contribution must be fully earned by the time deferrals equal 5% of compensation. (Note that the definition of compensation used for both safe harbors must be a uniform definition that satisfies the nondiscrimination requirements of Code Section 414(s) and its regulations.)

==> ACP Safe Harbor. Matching contributions that satisfy the ADP safe harbor under a QACA will need to satisfy the same matching contribution limitations as your existing safe harbor in order to qualify for the ACP safe harbor. (The ACP safe harbor limits the rate at which matching contributions can be made, the rate of deferral that can be matched, and the amount of discretionary matching contributions that can be made.) As with your existing safe harbor, if your plan has no matching contributions other than those required to satisfy the ADP safe harbor, the ACP safe harbor will be satisfied automatically. Remember, though, that if a plan permits after-tax contributions, the ACP test must still be performed for the after-tax contributions.

==> Two-Year Vesting Permitted. The QACA safe harbor permits the employer contributions (either matching or nonelective) to be subject to a two-year vesting schedule, whereas your existing safe harbor requires those contributions to be 100% vested.

==> Initial and Annual Notice Requirements. Both safe harbors require an initial and annual notice, but the QACA notice, in addition to satisfying the requirements for your existing safe harbor notice, must include descriptions of the automatic deferral feature and the default investment that the plan will use in the absence of employees' investment elections.

Quarterly Review

Vol XVIII; Number 2

July, 2008

==> Optional 90-Day Withdrawal Features. A QACA also can offer a 90-day withdrawal option for employees' first automatic deferrals if the plan meets certain additional requirements with respect to the default investment selected. (An automatic contribution arrangement that allows 90-day withdrawals is known as an eligible automatic contribution arrangement (EACA).)

In most other respects, the two safe harbors are the same, including the restrictions on distributions and the requirement that the safe harbor amendment generally be adopted before the beginning of the plan year and be in place for a full plan year. For more information, see EBIA's 401(k) Plans manual at Sections III.B.4 ("Chart Comparing Types of 401(k) Plans") and XIX.D ("QACA: Automatic Contribution Requirements and Options").

Contributing Editors: EBIA Staff.

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QUESTION: Our Company intends to establish a wellness program as of the beginning of next year. Would employees who are covered by the new program be ineligible for HSA contributions?

ANSWER: It depends on how the wellness program is designed. By way of background, to be eligible for HSA contributions, an individual generally cannot have health coverage other than high-deductible health plan (HDHP) coverage. This generally means that an HSA-eligible individual cannot be covered by a health plan that provides coverage below the HDHP deductible. However, there are certain types of non-HDHP coverage that an HSA-eligible individual can have, including coverage that falls within three categories: preventive care, "permitted insurance," or "permitted coverage."

IRS guidance provides that an individual will not fail to be HSA-eligible solely because he or she is covered under a wellness program, so long as the program "does not provide significant benefits in the nature of medical care or treatment," and therefore, is not considered a "health plan" for purposes of the HSA eligibility rules. When determining whether a wellness program provides significant benefits in the nature of medical care or treatment, screening and certain other preventive care services are disregarded. Disregarded services include screening for cancer, heart and vascular diseases, infectious diseases, mental health conditions, and substance abuse, as well as periodic health evaluations (including related tests and diagnostic procedures), routine prenatal and well-child

care, child and adult immunizations, tobacco cessation programs, and obesity weight-loss programs.

Thus, to ensure that your company's proposed wellness program does not interfere with employees' HSA eligibility, the program should be designed so that it does not provide significant benefits in the nature of medical care or treatment. IRS guidance provides an example of such a program. In the example, an employer offers a wellness program to all employees (regardless of their participation in the employer's health plan) that provides a wide range of education and fitness services designed to improve their overall health and to prevent illness, including: education; fitness, sports, and recreation activities; stress management; and health screening. Any costs charged to employees for participating in the program's services are separate from their coverage under the health plan. According to the IRS, this wellness program is not a "health plan," and therefore, does not interfere with HSA eligibility because it does not provide significant benefits in the nature of medical care or treatment.

For more information, see EBIA's Consumer-Driven Health Care manual at Sections VI ("Wellness and Disease-Management Programs"), XI.A ("General Rule--No Health Coverage Other Than HDHP Coverage"), and XI.F ("Many EAPs, Disease-Management Programs, and Wellness Programs Will Not Prevent HSA Eligibility"). Those considering or working with wellness programs may also be interested in our recent web seminar, "Wellness Programs in the Workplace: What's Allowed, What Isn't, and What Designs Work Best?," currently available for replay. For more information and to register, visit <http://www.ebia.com/Seminars/WebSeminar/19366> .

Contributing Editors: EBIA Staff.

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