

Quarterly Review

Vol. XVI; Number 4

January, 2007

From the Desk of the Editor

Greetings of the New Year. Since last we met, the **Ds** took control of Congress, and a **W** became speaker of the House; the latter a major milestone for women.

In his recent State of the Union Address the president unveiled his new Affordable, Accessible, and Flexible Health Coverage proposal. The People want action but will this proposal resonate with the People and the new Congress?

The **Ds** are not fans of Consumer Directed Health Care (CDHC) or the President's pet Health Savings Accounts (HSAs). The improvements to HSA Rules passed by the Republican-controlled Congress in December (see page 4) was predicted by a former Treasury official to be the last pro-HSA legislation we see during the next two years. However, like the President, a few powerful **Ds** are not fans of IRS Code §125 plans. Charlie Rangel **D**, new Chairman of Ways and Means, has demonstrated no fondness for café plans through the years. The President and Democrats may be more in tune than is realized.

Anticipating that the proposal can get some traction somewhere, our **Featured Article** this month is on the impact of the President's plan. **From the Hill** provides some insight into various coalitions forming to promote alternative strategies. It's too soon to know or to opine on the **Ds'** partisan and/or legislative response.

In the News we've included some IRS rulings that will expand the use of the EZ Reimburse[®] electronic payment card. In our **Guest Articles**, we have included an excellent EBIA article on IRS final regulations related to the use of electronic media: electronic records, signatures, notices, etc.

With this issue we have a new contributor, Mike Sheridan, FBMC founder and chairman. Mike's article discusses the fund performance for the 401(k) plans we manage.

Enjoy, Trish

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Featured Article

Impact: Bush "Proposal" on Healthcare

Trish Neely, CFCI

The President has proposed a grand plan to reform the tax code and help states make affordable health insurance available to their citizens. The plan levels the playing field for those with and without workplace health coverage. The plan also levels the field between what the Bush Administration refers to as **basic policies** compared to **gold-plated plans**. The President remains steadfast in his belief that consumer directed health care will provide the foundation for the health care reforms needed to address the uninsured and underinsured. He may be right.

Notwithstanding the wide speculation about the political viability of the plan or the fact that coalitions of special interest groups are creating their own plans, (see From the Hill, page 3); and regardless of your agreement or disagreement with the approach, it's important to understand the dynamics of the president's proposal and its possible impact on employer-provided health care as we currently know it.

The proposal will give a flat, **above-the-line**, standard deduction for anybody who purchases health insurance – no matter the cost and no

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matter where or how it's purchased. This feature is designed to correct what is considered an inequity in the tax code that penalizes people who do not get health insurance through their employers.

Effective in 2009, the tax deduction for individual coverage is \$7.5K; the deduction for family coverage is \$20K; thereafter it will be indexed annually to the Consumer Price Index (CPI). For those at the bottom end who make too much to qualify for Medicaid and not enough to benefit from the tax deduction, another component of the proposal, the **Affordable Choices initiative**, in concert with the States is proposed to fill in the gaps. This initiative is expected to encourage States to innovate and expand upon current Medicaid coverages.

In analyzing the President's plan, some concerns have been raised for individuals and for employers that we expect will form the basis for debate, political maneuvering, campaign promises and speeches and plenty of lobbying.

Adjusting the deduction annually is welcome, but indexing to the CPI appears to disregard the more recent double-digit increases in health care spending. Increased costs could quickly outpace the standard deduction and then what? Proposal supporters believe that the plan will actually help rein in runaway health care spending and double-digit increases with 1) better decisions by consumers, 2) increased competition amongst healthcare providers, and 3) the development of new cost-effective technologies.

Others contend that individuals may elect to obtain less expensive coverage to stay beneath the standard deductions at the risk of exposing themselves to serious health issues – thus contributing to further rather than solving the problem of the underinsured.

In addition, when an individual goes outside the workplace to seek less expensive coverage, there is the potential for adverse selection in employer-sponsored plans. This may trigger the exit of employers from the employer-based health care system entirely. The elderly, sickly, or those with pre-existing conditions could have a hard time purchasing affordable individual insurance within the standard deduction parameters. Since the

President appears none too keen on workplace coverages, this may be part of the grand scheme. Critics might say to the president, **be careful what you wish for**. The answer may lay with the success or failure of the Affordable Choices initiative.

Under the proposal, the **value** of Employer-provided health coverage would still be deductible by the employer as a business expense but would be taxable to the individual. How does this translate into pros or cons for the employee?

Where the current or future value of employer provided coverage exceeds the \$7.5 or \$15K standard deductions, there would be a net increase in taxes to the individual; where the value is less than the standard deductions, there would be a net decrease in taxes.

In a press briefing, Katherine Baicker, Council of Economic Advisors stated that the president's proposal will result in lower taxes for about 80% of employer-provided policies – estimated to impact 100 million employees. Those with more generous policies (an estimated 30 million employees) will see an increase unless they choose less expensive health plans. An article on the White House home page states that those with more generous policies will have the option to adjust their compensation to have lower premiums and higher wages to offset the tax change. (whitehouse.gov/infocus/healthcare)

Section 125 would no longer apply to health coverage; Health FSAs and HRAs would not exist; HSAs coupled with HDHPs will fill the void.

Although unclear as to the applicability to health coverages that are not § 213(d) eligible, it appears the proposal does apply to all other health coverages, including dental, vision, and EAP.

Also unclear is the impact of the tax changes to state income taxes and employment taxes.

We will be attending an industry teleconference mid-February to discuss the proposal in more detail and will update you as more details become known. In the interim, if you would like to continue a dialogue, please email tneely@fbmc-benefits.com.

A Perspective from the Hill

Robert McKnight, Senator; Senior VP

We have all heard the expression, “Politics makes strange bed fellows.”

Students of Capitol Hill can cite example after example. But the latest as reported in the January 17th issue of the Wall Street Journal is a real doozy!!

According to the Journal, an unlikely coalition of business, the elderly and unions was announced with the objective of convincing President Bush and the Congress that affordable health care is a critical problem. Although not included in the announcement, it is widely anticipated that benefits, including some of new tax favored programs, will be included in the debate. The organizations participating in the coalition are some of the largest and most recognized in Washington: The American Association of Retired Persons (“AARP”), The Business Roundtable, and the Service Employees International Union (“SEIU”). In addition to the WSJ article, the 3 organizations placed a full page color advertisement in the newspaper announcing formation of the coalition. The heart of their announcement is that they intend on addressing the issue of health-care overhaul through a mixture of advertising, lobbying, and public out reach.

According to the Journal, “The likelihood of these three groups—which have vastly different constituencies and political leanings—agreeing on a single approach is unlikely.” It is even more unlikely that such an agreement could be reached as the campaign starts. The Journal article also pointed out that later this week, 16 more disparate organizations, including the US Chamber of Commerce, physicians, health insurers and advocacy groups plan to introduce their own bipartisan approach to this problem of uninsured Americans. Not to be out done, several lawmakers on both sides of the isle have announced plans to introduce legislation addressing the issue, and President Bush has offered his own solution in his State of The Union address.

Andrew Stern, head of the SEIU, was quoted in the Journal article, “The winds of change are blowing. I think it’s now time for our Congress to step up to the plate.” No mincing of words from that strange bed fellow.

In the News

Private Letter Ruling (PLR) Invalidates HRA Program

FBMC Staff

Writing on behalf of the IRS, Harry Beker, Branch Chief concluded that an arrangement whereby employees electively chose future HRA benefits in lieu of wages or vacation benefits was **invalid** and contributions are not excludable from gross income.

This plan design may sound familiar to some of our Florida clients and friends as it was marketed several years back to a number of public employers.

Those who established these plans either are or will be undergoing payroll audits by the IRS to determine Federal tax consequences.

For more details about the specific plan design in question and a copy of the ruling, log onto <http://www.irs.gov/pub/irs-wd/0704005.pdf>.

IRS Issues Transition Relief for Grocers & Retailers

Kendall Hall, Card Services Manager
Trish Neely, CFCI

In reaction to industry concerns voiced loud and clear following the long-awaited and much anticipated debit card guidance in 2006 (IRS ruling 2006-69), the IRS issued transition relief in December. The relief treats certain merchants: grocers, discount stores, wholesale clubs, and mail order retailers, as merchants with a health care related merchant category code for 2007. So it’s one more year to be treated like merchants with medical MCCs under the original IRS health benefit card ruling (IRS ruling 2003-43). The normal electronic card substantiation rules

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(including pay and chase) apply during this time. Effective 1/1/08 vendors either must have a health care MCC or they must use an inventory control system as described in Notice 2006-69.

We are once again permitting expenses at these vendors to be paid with our electronic payment card per the transition relief.

New Employer Prohibitions for TRICARE

Tina Bischoff, CFCI

On October 17, 2006, President Bush signed the John Warner National Defense Authorization Act. Certain provisions and amendments regulate the coordination between group health plan coverage and TRICARE coverage. If you have at least 20 employees, you are subject to this Act.

Effective January 1, 2008, employers will be prohibited from offering financial or other incentives to their TRICARE-eligible employees.

Congress became aware that this was occurring and was displeased that employers were using these tactics to dissuade their TRICARE-eligible employees from continuing their coverage or enrolling in their employers' group health plans. (A group health plan as defined by TRICARE is "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) to provide health care (directly or otherwise)" to employees, former employees, and their families, among others.)

What is TRICARE? It is the Defense Department's managed health care program for active-duty military, active-duty service families, retirees and their families, and others. Now that they have employees (and spouses of their employees) in the military reserves who are being called up for active duty, employers contemplated reducing their claims experience and participation levels under their group health plans by encouraging TRICARE-eligible employees to let the federal government cover them and their families.

Employers should take note that under the new TRICARE rules:

- they cannot prevent TRICARE-eligible employees from participating in their group health plans.
- their group health plans must pay primary to TRICARE.
- TRICARE-eligible employees and their spouses will be entitled to the same benefits as their non-TRICARE-eligible employees.
- they cannot impose conditions on group health plan eligibility or benefits solely because of an employee's eligibility for TRICARE.

While it's still early, employers should review their plan designs with their insurers, the relationship between their group health plans and TRICARE, and their administrative practices because, in the absence of any further guidance or exceptions, *the respite provided by this Act will expire prior to 1/1/2008.*

In addition, to avoid incurring a civil penalty of up to \$5,000 for each TRICARE rule violation, employers should look over and modify (as necessary) any references to TRICARE coverage that may appear in their plan documentation and enrollment and/or communication materials.

HR 6111: Tax Relief and Health Care Act of 2006

Tina Bischoff, CFCI

This Act makes important changes to HSA contribution limits, comparability rules, HRA and health FSA interaction, and much more.

Effective **January 1, 2007** (unless otherwise noted below) and *provided certain conditions are met*, improvements under the Act include:

- ✓ **HSA maximum statutory limit contributions** will become much more consumer-friendly. The Act repeals the "lesser of an individual's HDHP deductible and HSA statutory limit" by permitting HSA eligible individuals to contribute up to their annual, maximum statutory HSA contribution limit. In 2007, this will mean that HSA eligible individuals with self-only HDHP coverage or family HDHP coverage may contribute up to \$2,850 and \$5,650 respectively even if their HDHP deductibles are less.

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- ✓ **Mid-year enrollees** will be allowed to make *full-year* contributions. If an individual becomes HSA eligible on or before December 1st of any year, that individual may be treated as if he or she had been covered by the same HDHP all year, for purposes of calculating their annual maximum HSA statutory contribution limit. Prior to January 1, 2007, an individual's annual HSA contribution limit was the sum of the monthly limits for each month he or she was an HSA eligible individual during the year. The monthly limits were 1/12th of the maximum annual HSA contribution amount. Assuming that an individual enrolls in September 2007 for HDHP self-only coverage, that individual will be able to contribute up to his maximum annual HSA statutory limit (\$2,850 for self-only coverage in 2007).

But if an individual does not remain HSA eligible during the following tax year, the portion of HSA contributions attributable to months that the individual was not actually HSA eligible will be included in their gross income, subject to a 10% penalty (unless the individual dies or becomes disabled).

- ✓ On a non-discriminatory basis, a **one time, direct tax-free transfer** of the *lesser* of the health FSA and/or HRA account balance in effect on September 21, 2006, or the balance as of the date of the transfer to an HSA, is permitted at any time prior to January 1, 2012. Under current law, no amounts may be transferred from an HRA or health FSA to an HSA. The transfer allowed in 2007 must be made directly by the Employer to the HSA custodian /trustee and *will not decrease the amount that may be contributed to the HSA during the year*. Employers making this new transfer opportunity available to any employee should make it available to all employees who are covered under the Employer's HDHPs to avoid a 35% excise tax.
- ✓ A **one-time, irrevocable tax-free trustee-to-trustee transfer of IRA funds to an HSA** will be allowed as long as such transferred amount does not exceed the annual maximum statutory HSA contribution limits. *But this IRS transfer is handled differently from the health*

FSA /HRA transfers above in that any amount transferred from an IRA to an HSA will reduce the maximum amount that may be contributed to the HSA during the year. Current law does not allow this type of transfer.

- ✓ That if an Employer's health FSA plan offers a "**grace period**," an HSA eligible individual may establish and/or contribute to an HSA if either (i) he or she has a zero balance remaining in their health FSA on the last day of the plan year, *or* (ii) their Employer transferred their entire health FSA balance to an HSA as of the last day of the plan year.

Current law denies an otherwise HSA eligible individual from establishing or contributing to an HSA if that individual participated in a full health FSA plan on the last day of the plan year regardless of whether the individual's health FSA balance is zero on the last day of the plan year. This meant that the individual had to wait until the first calendar month beginning after the grace period ended before being able to establish or contribute to an HSA. In 2007, an HSA eligible individual may contribute to the HSA during the 2-1/2 month health FSA grace period if their account balance on the last day of the plan year is zero, or if their Employer transfers their entire balance to the HSA as of the last day of the plan year.

- ✓ As an exception to the HSA comparability rules, Employers making HSA contributions outside of a Section 125 cafeteria plan will be permitted to make a **larger contribution for non-highly compensated employees** than to the HSAs of highly compensated employees.
- ✓ **Earlier indexing of HSA dollar limits** will be published no later than June 1st of each year commencing with the 2008 HSA cost-of-living-adjustments to be determined in 2007.

As with most regulatory changes (welcomed or otherwise), additional guidance is needed from the Treasury to ensure proper compliance with the application of some of these changes. For example, transfers from health FSAs raise questions such as how balances are to be calculated. The Treasury has indicated that such

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guidance will be forthcoming as part of their Grab Bag of HSA Guidance. We will keep you updated.

Text from Benefits Alert 2006-08, distributed in December 2006.

Debit Cards & Smart Cards Ok with § 132 Transportation Benefits

Tina Bischoff

RR 2006-47, effective 1/1/2008, permits the use of an electronic payment card with tax-free transportation benefits.

This ruling does not offer the universal remedy contemplated by many in the industry but it does provide clarification on the following points:

- ✓ A debit card using MCC-based processing for transit expenses is not considered a voucher because the IRS believes it possible that the card may be used by merchants to sell merchandise other than transit passes.

Because this debit card arrangement is not considered a voucher, it cannot be used *if vouchers are readily available*.

But in those narrow circumstances where an MCC-restricted debit card can be used, the ruling requires inflexible substantiation, reporting and certification procedures involving **initial substantiation** (similar to the recent debit card guidance for dependent care expenses), the **Employer's review of periodic statements** showing each employee's debit card activities, and an **employee's written certification** that he or she used the card only to purchase fare media.

- ✓ A smart card arrangement is permitted and considered by the IRS to be a "voucher" unlike the MCC-restricted debit card. Because a "smart card" contains a memory chip that stores the serial number of the card and the value of the fare media, it cannot be used for anything other than transit expenses. Thus, the substantiation, Employer reporting, and employee certification requirements under the ruling are automatically met.
- ✓ A terminal-based debit card arrangement is also permitted under the ruling and considered by the IRS to be a "voucher" unlike the MCC-restricted debit card.

A "terminal-based debit card" is one that can only be used at merchant terminals that sell fare media for a transit system. Employers allot to each card, on a monthly basis, an amount no greater than

the legal limit (\$110 for 2007) for tax-free transit expenses. Because of its restricted use, a terminal-based debit card automatically meets the substantiation, reporting and certification requirements under the ruling. Nothing further is required of the employee or Employer.

Industry experts, based upon non-binding informal IRS guidance, have indicated that Employers may also allow cash reimbursements in addition to offering terminal-restricted debit cards until further Treasury guidance is issued. (The issue requiring IRS clarification guidance is that if a terminal-restricted debit card is considered a "voucher" and thus "readily available," should the Employer bar employees not using the card from cash reimbursements?) **Text from Benefits Alert 2006-09 distributed 12/28/06.**

Fund Performance

Michael H. Sheridan, Investment Manager

Editor's Note

*You may not know that FBMC, through our wholly-owned subsidiary, Vista Management Company (VMC), manages very large 401K plans; Michael H. Sheridan, FBMC founder and Chairman, is the Investment Manager. Mike writes an investment column for the plan participant's in each issue of the VMC newsletter, and a **year in review** article each January. The latter looks at the previous and upcoming years and criticizes or praises his predictions from the previous year as well as makes new forecasts. The following article, taken by permission from the January 2007 issue, provides an indication of the fair and objective view of investments that we bring to our customers.*

Based on most indicators, the economy is preparing for a slow down. Although still healthy, the stock market has experienced some fluctuation this year but overall remains on the plus side. The market has almost recovered, on a five year basis, to the highs experienced in late 1999 and early 2000 before the beginning of the last recession.

Bond fund values dropped earlier this year as predicted but are gaining ground as interest rates appear to be stabilizing. Our earlier advice about investing new payroll contributions into one or more of the bond funds is beginning to pay off.

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We stick to our beginning prediction that, overall, the stock market will end 2006 with modest gains in the 5-10% range.

Our international fund, Europacific, continues to return surprisingly good gains as the predicted slow down in the global economy has not yet materialized.

Value and Equity Income funds, such as American, Investment Company of America; Goldman, Sachs, Growth and Income; and T.Rowe Price, Equity Income, have remained good investments as conservative, dividend paying, stocks have enjoyed good returns with lower risk than other stock investments.

Our mid-cap fund, Delaware, Growth Opportunities and the small-cap fund, T. Rowe Price, Small Cap Stock, have modest returns as these types of funds are beginning to lag behind the funds that invest in large cap stocks.

I am impressed with the returns of both of the Balanced funds, Goldman, Sachs and Vanguard, as a balance of stocks and bonds in one fund is returning good gains with much less risk than an all stock fund and provides better growth opportunity than an all bond fund.

As we reported earlier in the year, both the money market and the Vanguard, Short Term Treasury, funds have provided a minimum risk option for investment during a time of rising interest rates. I caution participants in these funds to reevaluate those positions if interest rates start to come down in the future, which seems to be likely.

Overall, we are pleased about your plan's funds performance. The exception is with American Century; Ultra. Patrick Peters and I recently interviewed this fund's manager and were pleased with his candor about having too much of a position in tech stocks that had not grown as they were predicted to grow this year. We are not ready to give up on them but are concerned that, if the economy slows, as we think it will, then the anticipated gains in this sector may not happen at all and this fund will remain a laggard.

If you want to participate in large cap growth funds, the American, Growth, may be a better alternative. We will continue to watch them.

Is Avian Flu the New Y2K - *Lots of hype and no big bang?*

Kedra Baumgardner, Security Officer

Consider this if you will. . .

Only three conditions are necessary for a pandemic to start. First a new influenza virus subtype must emerge; then it infects humans and causes serious illness; then it spreads and is sustained like wildfire.

Health experts have been monitoring the H5N1 strain of Avian Flu for almost eight years. This virus has already met the first two conditions: it's new and it's infected over 200 humans (killing over half). So far, we've been spared the mutation – the jump from bird to human - that can cause the pandemic.

So just like Y2K, many will have to plan for the worst and hope for the best. Your organization size and type will dictate whether you dedicate resources to create a pandemic plan that addresses the worst case scenario, or you adopt a less extreme approach.

Some Important Facts

The typical time between infection and onset of symptoms is 1.5 to 2 days. Persons who are infected can shed the virus for ½ to 1 day before they become ill. Thus they can transmit the disease before it can be recognized that they have become infected.

Once a fully contagious virus emerges, its global spread is considered inevitable. With air travel the virus could reach all continents in less than 3 months.

Assuming they are developed, supplies of vaccines and antiviral drugs will likely be inadequate.

Retail sales will suffer as people avoid public places.

Transport, supply systems and basic goods and services may be interrupted.

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Local epidemics will last 6 to 8 weeks, and you can expect multiple waves of the virus.

At least 20% of your employees will contract the disease, and it will be fatal for some of them.

Caring for family members, school closings, funerals, and fear of infection will bump absenteeism to 40% during the peak of a community outbreak, with staff being out for a minimum of two weeks at a time.

You should expect that your business partners will be impacted to the same degree as you. You must assume that they may not be able to provide the goods or services you require to operate at peak levels.

Start Planning Now

- Identify items that you should have in reserve or stockpiled such as: cleaning supplies, office supplies, and health supplies (masks, anti-bacterial soap, latex gloves)
- Develop a plan for distributing health supplies to employees, and a mechanism to collect and dispose of them.
- Develop plans to reduce employee face-to-face contact. For example, we are considering alternative mail collection and distribution methods and establishing web and video conferencing.
- Develop a plan for more frequent and thorough cleaning, focusing on desks, phones, keypads, sinks, railings, door handles, etc. Outline cleaning plans for areas where staff have become ill.
- Develop a plan to allow employees to work remotely (from home or other locations.)
- Evaluate all communication options to ensure you can stay in contact with employees whether at home or at work.
- Develop plans to cross-train employees.
- Develop an education program for employees that includes:
 - Basic information on the Avian Flu
 - signs and symptoms
 - how to prevent spread
 - what to do if you become ill at work
- Develop an emergency leave policy. A more liberal policy may be needed given that high

absenteeism is expected. Accumulated sick leave may be insufficient.

- Develop an emergency policy on travel restrictions.
- Develop procedures for handling employees who become ill at work.
- Develop Return to Work procedures. Addresses issues such as how long employees must be symptom-free before they can return, whether a doctor's note is required, etc.
- Establish a mechanism to centralize information and track sickness among employees. It will be crucial to know which employees are sick, which have survived and are immune, which have lost family members, etc.
- Develop a plan for how you will pay for/reimburse employees for work-at-home costs such as internet connection, second phone line, cell phone, printers, office supplies, etc. Addresses issues such as whether work at home is mandatory or voluntary.
- Identify key employees that might need redundant communications at home (cable modem and DSL for example).
- Identify key service providers and their contingency plans. Develop strategies to work around loss of or reduced service from these providers.
- Implement an analysis of essential and non-essential functions in each department, especially HR since they will be taking on additional work during the crisis. Identify core activities or basic minimum services. You may need to identify services you will cease to provide or scale down at each phase of the crisis.

The World Health Organization (WHO) and the Federal government have established phases to identify different levels of a pandemic threat. FBMC will use these phases as guides to our response levels. (See the table on Page XX) For information about our plan or if you just want to compare notes, contact me at kbaumgardner@fbmc-benefits.com.

Visit the following web sites for more detailed information on Avian Flu:

Centers for Disease Control

<http://www.cdc.gov/flu/avian/>

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World Health Organization

http://www.who.int/csr/disease/avian_influenza/en/

I have attached a table from the National Strategy for Pandemic Influenza, Implementation Plan, Homeland Security Council, May 2006. See page 13 of this newsletter.

Questions from our Clients

Tina Bischoff, CFCL, Compliance Officer

Editor's Note

Most of you know Tina. As our resident expert for issues related to flex plans she usually researches and responds to your inquiries. With this issue we will start including a section on interesting or unique questions, and those that are asked on a regular basis. Understandably, this past quarter saw an increase in questions related to yearend tax preparation. Different versions of the following two questions were raised repeatedly. We hope you find the answers informative.

Question We have an employee who enrolled for the max in DCAP and evidently, so did his wife who is not a State employee and is on a calendar year. They are going to be approximately \$2500 over the \$5000/year maximum for DCAP between the two of them. I think the only way I can let him out of the program is due to him coordinating with his wife's annual enrollment period (I'm assuming is coming up soon). My question is with regard to the overpayment. Is the only penalty the fact the the member would have to pay taxes on the amount they are over \$5000? And, is there any other change in status that would allow our member out of the program since he and his wife both enrolled for too much together?

Answer The IRS takes the position that ignorance of the law is not considered a valid CIS event. In fact, the IRS uses a term for the exact situation presented in your e-mail below -- "double-dipping."

In a nutshell, the IRS does not expect Employers to police the *tax filing status* of their DCAP participants. If an Employer becomes aware of a double-dipping situation during a plan year, and the employee involved has been using his or her DCAP, the plan should continue to reimburse the

employee's eligible, dependent care expenses up to his or her maximum annual amount. Using this approach will not cause any harm to an Employer's DCAP.

At the time when the employee and his or her spouse file their 2006 IRS Form 1040, they will then have to report on IRS Form 2441 the amount of their dependent care reimbursements that exceeded their tax-filing status limit so that the excess reimbursements can be treated as taxable income. This is an example of why Employers are required to report in Box 10 on employees' Forms W-2 the amount of the contributions made to their DFSAs.

Question We have an employee who in 2006 elected a full purpose Health FSA through our plan and also established an HSA through his financial institution. We would have caught this had he enrolled in our HSA and we would have placed him in our limited purpose FSA. His accountant caught the problem and explained the tax consequences. The employee has asked that we move his contributions into the LP-MFSA. We want to help, but not at the expense of jeopardizing our plan. Can you explain the tax consequences and offer some suggestions as to what we might legally do to help our employee?

Answer In essence what has happened is that this employee was likely not HSA-eligible at the time the account was established - especially if he was permitted to also participate in a regular Health FSA at the same time. Under the rules of the program, where there is any overlap of the Health FSA and the HSA, the contributions made to the HSA would not be tax deductible, ergo any contributions made into the HSA (whether individual or Employer contributions) during this overlap time would be excess contributions subject to a 6% tax.

Your concerns are well-founded. Changing this employee's 2006 Health FSA election to a LP-MFSA at this late date (12/2006) is a bad idea - the cow is already out of the barn.... The employee has been reimbursed for expenses that do not fit the criteria of limited purpose. While we would not recommend trying to "undo" the payments or permit the employee to substitute other expenses, this approach would have been

more feasible had the error been caught at the beginning and not the end of the plan year.

After some research, several of our outside experts have offered some thoughts and remedies.

It may be that the agreement itself provides a correction method when an account holder discovers he or she was ineligible to establish an HSA. It is conceivable that the HSA could be recharacterized as a separate and different trust or custodial arrangement through the financial institution. If there is no HSA, then one might argue there are no excess contributions and no excise tax.

Therefore you might suggest to your employee that he and/or his financial advisor read through the trust agreement with his financial institution and discuss options.

GUEST ARTICLES

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IRS ISSUES FINAL REGULATIONS ON USE OF ELECTRONIC MEDIA FOR BENEFIT-RELATED NOTICES, ELECTIONS, AND CONSENTS

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[Treas. Reg. Secs. 1.401(a)-21, 1.72(p)-1, 1.132-9(b), 1.402(f)-1, 1.411(a)-11, 1.417(a)(3)-1, .7476-2, 35.3405-1, and 54.4980F-1 (Oct.20, 2006)]
For a copy: <http://www.irs.gov/pub/irs-reg/td9294.pdf>

The IRS has issued final regulations on the use of electronic media (such as websites, e-mail, telephone systems, magnetic disks, and

CD-ROMs) for certain notices, elections, and consents provided to or made by employee benefit plan participants and beneficiaries. The regulations apply to various retirement plans, including 401(k) plans, as well as to cafeteria plans, accident and health plans, HSAs, Archer MSAs, qualified transportation plans, qualified educational assistance plans, and individual retirement plans (including IRAs, Roth IRAs, and deemed IRAs under a qualified employer plan). The rules do not apply to notices, elections, consents, disclosures, or obligations required by ERISA that are regulated by the DOL or PBGC (e.g., SPDs, SARs, or COBRA notices).

The final regulations generally adopt the proposed regulations issued in July 2005 (see our article at <http://www.ebia.com/WeeklyArchives/401k/Statutes/16371> (Premium Access subscription required)).

They are effective on October 20, 2006 and generally apply to applicable notices provided, and participant elections made, on or after January 1, 2007. Here are some highlights:

==> E-SIGN. The final regulations reflect the provisions of E-SIGN, which generally provide that electronic records and signatures are given the same legal effect as paper records and signatures. The final regulations clarify that, in compliance with E-SIGN, an electronic record of a notice or election that is not maintained in a form that is capable of being retained and accurately reproduced may be denied legal effect or enforceability.

==> Notices. The final regulations retain the two methods for providing notices described in the proposed regulations. The first method adopts the consumer consent rules of E-SIGN and requires, among other things, that a plan obtain a recipient's consent before providing an electronic notice. The preamble notes that the final regulations retain this method without substantive change and that many of the concerns of those who commented are ameliorated by the availability of the alternative method. The alternative method generally follows IRS regulations for certain retirement plan notices that were issued shortly before E-SIGN was enacted, and requires that recipients (1) have the "effective ability to access" the electronic medium used to provide the notice; and (2) be advised that they

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can request a paper version of the notice at no charge (and, upon request, the free paper copy must be provided). Regardless of which approach is used, the system for electronic delivery of notices must provide the information "in a manner no less understandable" than a written paper document, and the transmission must alert the recipient to its significance and include any instructions needed to access the notice.

==> Elections and Consents. The final regulations generally retain the requirements in the proposed regulations for elections and consents made by a participant or beneficiary. The final regulations require that a participant or beneficiary be effectively able to access the electronic system used to make the election, but they do not require that a plan also permit the election to be made by paper as an alternative to using the electronic system. However, the regulations do not apply to a participant or beneficiary who is not effectively able to access the electronic system, so the plan must offer such individuals the right to make an election in another medium (such as a paper election). The preamble comments that plans failing to offer paper or an electronic medium that a participant or beneficiary is effectively able to access will not only fail to comply with the participant election requirements but would also likely violate other qualification requirements, such as the requirement to operate in compliance with plan terms and the requirement that benefits, rights, and features be made available in a nondiscriminatory manner. The final regulations also continue to require authentication of elections (electronic systems must be reasonably designed to preclude any person other than the appropriate individual from making the election), and they clarify that whether this condition is satisfied is based on facts and circumstances, including the potential for conflict of interest (which is of particular concern with spousal consents).

==> Spousal Consent Issues. The final regulations, like the proposed regulations, extend the use of electronic media to the notices and elections required for plans subject to the QJSA rules of Code Section 417, including participant and spousal consents.

The final regulations retain the rule in the proposed regulations that the signature of a spouse be witnessed in the physical presence of

the plan representative or notary public. The preamble comments that the IRS believes that permitting electronic notarization of spousal consents in conjunction with physical presence properly balances minimizing the burden of plan administration with protecting the rights of spouses. However, in recognition of how quickly technology evolves, the regulations authorize future guidance (through means less formal than amended regulations), should the IRS later determine that an electronic system can provide the same safeguards as are provided through the physical presence requirement.

EBIA Comment: The IRS final regulations provide a welcome consolidation of its electronic media rules for certain employee benefit plan notices, consents, and elections. As the preamble explains, these final regulations generally are the exclusive rules for electronically providing applicable notices and elections that the Code requires be in writing, and they serve as a safe harbor method for any applicable notices or elections that are not required by the Code to be in writing (such as plan enrollments, direct rollover elections, and beneficiary designations). For more information, see EBIA's 401(k) Plans manual at Sections XXVII.H ("Electronic Delivery of Participant Forms and Notices Required by the Code") and XXIX.G ("Using Electronic Plan Administration"). For more information about cafeteria plans, see EBIA's Cafeteria Plans manual; and for more information about HSAs and Archer MSAs, see EBIA's Consumer-Driven Health Care manual.

Contributing Editors: EBIA Staff.

SUPREME COURT'S KNUDSON DECISION DOES NOT LIMIT PLAN'S RIGHT TO RECOVER BENEFIT OVERPAYMENTS BY REDUCING FUTURE BENEFITS

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[Northcutt v. Gen. Motors Hourly-Rate Employees Pension Plan, 2006 U.S. App. LEXIS 27163 (7th Cir. 2006)] For a copy:

http://www.ca7.uscourts.gov/fdocs/docs.fwx?case_no=05-4484&submit=showdkt

The Seventh Circuit has upheld the right of ERISA plans to recover overpaid benefits through

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reductions in future benefit payments. (See our article on the lower court decision in this case at <http://www.ebia.com/WeeklyArchives/ERISA/CourtiCases/18130> (Premium Access subscription required).) The case involved two participants, one receiving benefits under an employer-sponsored long-term disability plan and one receiving supplemental disability benefits under the employer's pension plan. The plans' terms provided that benefits would be reduced for any period in which a participant was also entitled to Social Security benefits, and participants who received retroactive Social Security awards were required to repay benefit amounts that became overpayments as a result. (Indeed, both participants signed acknowledgements of this repayment obligation.) In the event that repayments were not made, each plan also provided for reduction or suspension of future benefit payments to recoup overpayments. After both participants received lump-sum Social Security awards and failed to make the required repayments, the plans suspended their benefit payments accordingly. The participants sued, but the lower court entered judgment for the plans.

In affirming, the Seventh Circuit rejected the participants' characterization of the Supreme Court's decision in the Knudson case as having deprived ERISA plans of all ability to enforce reimbursement rights, including through benefit reductions. Instead, the court found Knudson inapplicable because that case addressed the judicial remedies available in a civil action under ERISA, whereas this case did not involve any civil action by the plans. The Seventh Circuit also agreed with the lower court that recovery of overpayments in accordance with plan provisions clearly authorizing benefit reductions did not violate any aspect of ERISA that the participants could identify, and did not violate any clearly articulated policy of ERISA. Indeed, the court said, recovery of overpayments fostered the integrity of ERISA plans and ensured the availability of funds for other participants.

EBIA Comment: We report on this case for readers concerned with recovery of overpaid benefits and for those keeping track of post-Knudson developments. On this latter point, because the briefs in this case were filed before the Supreme Court issued its post-Knudson decision in the Sereboff case, the court did not

address whether Sereboff might actually lend support to the plans' "self help" approach to recovering benefits. Of course, self-help will not be practical in many situations. Health plans, for example, seeking to recover large benefit overpayments are unlikely to have the opportunity to reduce equally large future payments; 401(k) plans that make mistaken lump-sum payments have no future benefits to reduce; and so on. For more information, see EBIA's ERISA Compliance manual at Section XXXII.L ("Recovering Overpaid Plan Benefits") and EBIA's 401(k) Plans manual at Section XXX.F ("Recouping Overpaid Plan Benefits").

Contributing Editors: EBIA Staff.

Chart from the World Health Organization follows this page

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WHO Phases		Federal Government Stages	
INTER-PANDEMIC PERIOD			
1	No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human disease is considered to be low.	0	New domestic animal outbreak in at-risk country.
2	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.		
PANDEMIC ALERT PERIOD			
3	Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.	0	New domestic animal outbreak in at-risk country.
		1	Suspected human outbreak overseas.
4	Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.	2	Confirmed human outbreak overseas.
5	Larger cluster(s) but human-to-human spread still localized, suggesting that virus is becoming increasingly better adapted to humans, but may not yet be fully transmissible (substantial pandemic risk).		
PANDEMIC PERIOD			
6	Pandemic phase: increased and sustained transmission in general population.	3	Widespread human outbreaks in multiple locations overseas.
		4	First human case in North America.
		5	Spread throughout United States.
		6	Recovery and preparation for subsequent waves.

Table provided courtesy of the National Strategy for Pandemic Influenza, Implementation Plan, Homeland Security Council, May 2006. See page 7 of this newsletter for the corresponding article.

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