

Quarterly Review

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From the Desk of the Editor

For days following Katrina I found myself unconsciously humming or just replaying the words "if it keeps on raining, the levee's going to break." *A Led Zeppelin classic; a national disaster.*

When you live near the Gulf Coast it is a fact of life that eventually you will experience a hurricane. There's the personal anguish of wondering is our city next, will it damage my house? Then there is the business side: do we have adequate insurance, is the disaster recovery plan fool proof, what about that business interruption insurance – will it cover the most important instances of interruption?

In a repeat of 2004, this hurricane season has crippled some of our large public employer clients. Once again we have coordinated with health and insurance providers to assure our client's employees (our customers) do not have gaps in insurance coverages. I would prefer a less needed distinction than to say it appears we are turning pro in this role. We are thankful for the measure of comfort, support and stability we've been able to provide in the face of destruction.

In this issue, I am repeating a timely and relevant article from a previous Quarterly Review that describes the steps we follow in helping our clients through a disaster following guidance we have received from Harry Beker's office.

I am also including a very touching article from an FBMC employee who lives in New Orleans and experienced first hand the storm and its aftermath.

And of course the standard regulatory fare – it wouldn't be a Quarterly Review without it. The featured article is on Health Savings Accounts. If the employer surveys and industry trends are correct, many of you are considering and will be adopting high deductible health plans and HSAs in the near future. This article will give you some of the basics as you begin to consider plan design strategies.

Trish Neely

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KATRINA

David Hanley, Client Liaison

As I watched Hurricane Katrina's track move a little more east of New Orleans from the safety of the hospital where my wife works in the small bayou community of Thibodaux, 60 miles southwest of New Orleans, I thought that New Orleans had once again dodged "the big one". Of course there would be the usual damage: downed trees, power lines, debris, and local street flooding that we all have become accustomed to with hurricanes down in south Louisiana. With anticipation, I returned home to the 100 year old house I remembered experiencing hurricane Betsy in when I was 5 to find minimal wind damage. I also found, what I thought at the time was an inconvenience - no electricity.

The next morning, I received a telephone call from my manager at FBMC, who informed me that it was being reported on the news that water was rising in New Orleans and they weren't sure where it was coming from. I turned on my battery powered radio to learn that a levee had breached and they were working to repair it. Later on that day, life as I knew it changed forever and for everyone in New Orleans. The levee repair failed and water from Lake Pontchartrain was pouring into the city. Most of the city would be under water within hours. Chills raced through my body - I could not believe this was happening. I called family who live in the city and who had evacuated to tell them the news. When I saw the TV reports

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of the human misery and the devastation of the city, I could not hold back tears. I worried about my friends, family and co-workers and wondered if they were safe.

New Orleans means so many things to so many people. For me, there are the childhood memories at the Audubon Zoo, the City Park carousel, Christmas in the Oaks, and my first streetcar ride. And there are the memories of Sunday afternoons at the lakefront, the Riverwalk, and the Jazz Festival; Mardi Gras parades on St. Charles Avenue, late night bars and music clubs uptown followed by breakfast at Camellia Grill; Saints games and Sugar Bowl games in the Superdome, Zephyrs baseball games; running in the Crescent City 10k Classic under the shade of oak trees, hearing the cool sounds of jazz and blues while strolling in the French Quarter, fine dining and the smell of Cajun and Creole cooking, the Saenger Theatre... I could go on and on. New Orleans had its own culture and a big easy way of life.

I wonder if life will ever be the same for those of us who call New Orleans home.

David Hanley has worked for FBMC for sixteen years in our New Orleans field office. He is currently working in Tallahassee and playing a key role in assisting our client recover from Katrina's wrath. Their new flex-plan had just been enrolled and was to be effective 9/1/05.

A Perspective from the Hill

Robert McKnight, Senator; Senior VP

The President is Accelerating His Lame Duck Status

From a benefits administration perspective, President Bush hit a home run in his first term. Not a day goes by without some mention of Consumer Driven Health Care and Health Savings Accounts tied to high deductible health plans. It is still not clear if this initiative pushed by the Bush Administration will truly benefit employers and employees, but it is the buzz in the industry without question. With such a foundation in place, it is surprising that the President appears to have lost his political momentum so quickly.

His support from the American people has dropped substantially to its lowest point ever. Many factors have contributed to this development: continued disdain for the war in Iraq; his mishandling of the aftermath of Katrina; the third largest budget deficit on record; skyrocketing gasoline prices; the indictment of his main supporter in the Congress, Majority Leader Tom Delay; the probable indictment of his long time political adviser Karl Rove and the indictment of the Vice President's Chief of Staff, Scooters Libbey; his handling of the nomination of Harriet Miers to the critical swing vote on the Supreme Court; the troubles of Senate Majority Leader Bill Frist; and the constant friction between the President and the probable Republican Presidential candidate, Senator John McCain (R.AZ). For the first time in many years, the Democrats are beginning to think they may have a chance to take back at least one of the chambers of Congressional power.

As a result of this deterioration, many benefits administration observers feel the key political player is now the powerful Chairman of the Senate Finance Committee, Senator Charles Grassley (R.IA). He has been a major player on discussions regarding benefits legislation, including the thorny "use it or lose it" rule. The outcome of all federal legislation will not doubt ride on the elections next year. In the meantime, we will watch to see if the President can reclaim his place at the benefits administration table.

Featured Article

HSA Comparability Regs Issued

Trish Neely, CFC
Chief Compliance Officer

On August 25, 2005, the IRS and Treasury issued proposed regulations providing further guidance on employer comparable contributions to Health Savings Accounts (HSAs) under §4980G of the Code.

The 2003 Medicare Modernization Act (MMA) added §§223 and 4980G to the Code. §223 permits eligible individuals to establish HSAs and §4980G requires comparability if an employer

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chooses to contribute. (Contributing is not a requirement.)

Comparability is satisfied by contributing the same dollar amount to **categories of employment** or the same percentage of the deductible of employees with the same **category of coverage**.

Categories of employment

The comparability rule applies to **employees** – both current and former*, falling within the same employment category. The **ONLY** employment categories are:

1. full-time employees;
2. part-time employees; and
3. retirees

* A special rules excludes COBRA participants.

Therefore, employment categories are not: salaried or non-salaried, exempt or non-exempt, management or non-management, or union or non-union. To divvy contributions in such a manner risks violating the comparability rules.

Contributions to individuals not considered employees are **not subject to** the comparability rule. For example: contributions to an independent contractor's HSA, a partner's HSA, or a sole proprietor's HSA.

Categories of coverage

Contributions can vary between coverage categories. There are only two categories of coverage that may be considered separate regardless of the number of categories within the high deductible health plan. These are **self-only** and every other coverage type: employee + one, employee + two, employee + family, employee and spouse, fall into **family** coverage:

1. self-only; and
2. family.

The key is to treat similarly situated employees the same.

Yes, an employer may provide a different contribution to full-time employees with self-only coverage vs. full-time employees with family coverage; or to part-time employees with self-only vs. family coverage.

Yes, an employer may provide a contribution to full-time and no contribution to part-time or retirees, or any similar variation.

Yes, a partnership may give partner A twice as much as partner B since they are not employees, and may give all full-time employees the same amount.

No, an employer may not provide a matching contribution or a percentage of the employee contribution.

No, an employer may not condition contributions on participation in disease management, wellness, or health assessments.

No, an employer may not base contributions on age or years of service.

Method & timing of funding the HSA

Employers may pre-fund the HSA, make one or two contributions throughout the year, make monthly contributions, or make contributions by 4/15 of the following year (look back).

A caution for employers who choose to pre-fund, once the contribution is made it belongs to the recipient. You may not request a refund if you err or if the employee terminates early.

A practical problem for employers who choose the look-back is making contributions to former employees for months that they were eligible. The level of due diligence in locating former employees is not defined.

Contributions do not have to be made for any employee that fails to open an HSA before the end of the calendar year. However, as long as the employee does open the account by 12/31, **ALL** contributions for the months in which the employee was eligible **MUST** be made.

Part-year employees receive a pro-rated amount that "bears the same ratio to the comparable amount as such portion bears to the entire calendar year" §4980E(d)(2)(B). In other words, if he/she joins the program in September, then the contribution will be 9/12 of what a similarly situated employee would receive.

Plan Design: Contributions may be conditioned to ER plan

The proposed regulations provide guidance regarding contributions where the employee has HDHP through the employer or through another source. As long as the employer conditions the contribution upon enrollment in the employer's HDHP, then an employee who acquires HDHP coverage elsewhere is not required to receive a comparable employer contribution. However, if the employer conditions the contribution only upon HDHP coverage, then comparability does apply. Plan design is important and Employer's who adopt HSAs should consider overall objectives and strategies.

For employers who are interested in maintaining some control over where the contributions are deposited, the IRS has informally stated that the comparability rule is not violated if the employer restricts contributions to a specific trustee. We prefer to see it in writing before we recommend this as a plan design option.

HSA contributions that are not subject to comparability

If your plan design strategy includes making matching contributions or conditioning contributions on wellness or other programs, then you may want to consider making your contributions through a cafeteria plan.

The proposed regulations confirm that contributions to an HSA made under a §125 Cafeteria Plan are not subject to comparability; however be careful, they **are** subject to non-discrimination testing rules, including: the eligibility rules, contributions & benefits tests, and key employee concentration tests.

Oops, we made a mistake

An employer who fails to comply with the comparability rule is subject to a 35% excise tax on all HSA contributions made during the calendar year (or those that should have been made during the calendar year!). Although an employer cannot take back too much (once given it belongs to the employee), an employer can cure a violation by making additional contributions before April 15th of the following year.

Where the failure is due to reasonable cause and not willful neglect, there may be a waiver of the Excise Tax. In an attempt to fit the punishment to the crime, consideration will be given to waiving all or a portion of the tax imposed under §4980G.

A copy of the guidance can be found at the following address:

[http://www.ustreas.gov/press/releases/reports/reg_13864704 .pdf](http://www.ustreas.gov/press/releases/reports/reg_13864704.pdf)

News Briefs

Grace Period for DCAP Plans

Trish Neely, CFC

On September 7, 2005, the IRS issued Internal **Revenue Notice 2005-61** to clarify the Form W-2 reporting requirements when an employer has adopted the Grace period for Dependent Care FSA.

"An employer that amends its cafeteria plan to provide a grace period for dependent care assistance may continue to rely on Notice 89-111, by reporting in Box 10 of Form W-2 the salary reduction amount elected by the employee for the year for dependent care assistance (plus any employer matching contributions attributable thereto)."

Caution: Although the Notice provides relief for Employer reporting, what the employee is required to report on Form 2441 for each tax year is not addressed by the Notice. Informally we have heard that changes will be made to the Form.

FBMC Clients Adopt the Grace Period

58% of FBMC clients are adopting the new grace period for their Medical Flexible Spending Account programs; of this number 8% are also adopting it for Dependent Care programs. This is consistent with industry averages.

Of the employers who are adopting the grace period, 80% are keeping the existing run-out period, 20% are extending the run-out period an additional 30 days.

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The 42% of FBMC employers not adopting the grace period cite concerns with explaining the program to their employees and a general disenchantment with the path the IRS chose to deal with **use it or lose it** as primary reasons.

Keeping up with the Feds

Terry Hume
Senior Marketing Specialist

The Office of Personnel Management (OPM) announced that the Federal Flexible Spending

Account Program is adopting the new grace period. OPM is also extending the run-out period an additional month to file claims. We have learned that effective in 2006, the contribution limit will be increased to \$5,000 for the Feds' Healthcare Spending Account.

IRS Increases Mileage Allowance

Tina Bischoff, CFC
Compliance Officer

Due to the IRS' keen awareness of recent increases in gasoline prices, the IRS has issued IRS Announcement 2005-71 (<http://www.irs.gov/pub/irs-drop/a-05-71.pdf>). This IRS Notice revises, for the remainder of this tax year, the 2005 standard mileage rate reimbursable under a health FSA, HRA, and HSA for the use of an automobile to obtain essential medical care. A copy of the IRS' press release on this notice can be located at <http://www.irs.ustreas.gov/newsroom/article/0..id=147423,00.html>.

For medical care received **on or after September 1, 2005**, the notice increases the medical mileage reimbursement rate from \$0.15 to \$0.22 per mile. ***This relief only applies to the last four months of 2005 (September – December).*** The medical mileage reimbursement rate of \$0.15 must still be used for the first eight months of 2005 (January through August).

Maximum 401(k) Contributions Increase

Holly Hance
Compliance Officer
Vista Management Company

As a reminder to our clients with 401(k) plans, last year the IRS published new contribution limits for the 2006 tax year as follows:

- \$15,000 for participants under age 50

- \$5,000 catch-up (\$20,000 total) for participants who are 50 or over or who will turn 50 in 2006.

FBMC Adopts New Plan Document Approach

Tina Bischoff, CFC & Trish Neely, CFC

With the assistance of the Alston & Bird law firm, we have adopted a new set of documents for use with our flexible benefit plans. We will begin using the documents immediately with new clients, and will transition existing clients over the next eighteen months.

The new approach is being adopted by many administrators in our industry. Referred to as a document wrap around approach, it consists of a Cafeteria Plan Document, Two Spending Account Documents, and a Summary Plan Description (SPD). The business rules and other plan details are contained within the SPD in an easy to read format. The plan documents themselves are now easier to read as we replaced the "old English style" legalese with a more straight-forward approach.

The SPD is written to be appropriate for private or public employers (ERISA or ERISA-exempt). There are several versions of SPD depending upon inclusion of HSA, HRA, limited purpose and/or full purpose MFSA, grace period/no grace period.

We now have a prototype Qualified Transportation Benefit (QTB) document for those clients who choose to adopt a §132 program and desire to have a formal document in place to include business rules even though its not required under the regs.

Date Incurred vs. Date Provided . . .

An age-old dilemma

Tina Bischoff, CFC & Trish Neely, CFC

The proposed cafeteria plan regs tell us that an expense is incurred when the medical care is provided that gives rise to the medical expense.

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Clearly it is not when the participant is billed, charged, or pays for the care. What is less clear and what is often a conundrum for plan sponsors and administrators is determining when the medical care is provided.

A doctor visit is pretty straight forward – it's the date the patient was seen; but what about some that aren't so obvious:

Is medical care provided the date I see my doctor and drop off my prescription, or the date I pick it up?

Is it the date my eyes are examined and I order new glasses, or the day they are delivered to me?

Is it the date that I order a medically necessary support mattress or the date that it finally arrives?

With few exceptions, FBMC plan sponsors have, with FBMC's guidance, required that the expense be reimbursed from the account that is active as of the **date** when the doctor visit occurs, when the eye glasses are delivered or when the RX is picked up.

For those plan sponsors who believe that date ordered is the correct date (rather than date delivered), our outside counsel recently opined that *it is supportable to take the position that a medical service has been rendered (at least in part) when a placed order has begun to be filled.*

OK, now we have established that date ordered or date delivered are both ok, what is left to talk about?

Where do we get the date? We and most administrators in our business use the date provided on the third party receipt attached to a claim form. Generally, we don't know if it's date ordered or date delivered. We rely upon the customer's signature that he/she has followed the plan rules.

What gets dicey is the overlap that occurs when the order is **placed** in one plan year and **picked up** in the next. We still rely upon the date on the third party receipt and follow the client's business rules. Invariably we have a customer who meant for the expense to be reimbursed from one plan year but because of the infamous date on the receipt or because of the client's business rules, we reject the request.

The grace period comes to the rescue for some.

After extensive research you finally order in September the orthopedic bed that your orthopedic surgeon prescribed and that you set aside health contributions to buy. You wait and wait and finally in December, you are told it's on back order until the first of the year – AARGH! No problem if your employer has adopted the grace period.

What if an employer has not adopted the grace period?

We recently posed this question to outside counsel. In situations that are outside of a participant's control, both the plan sponsor (employer) and administrator can be given the discretion to reimburse the cost of medically-related items out of the plan from which the participant intended it to be reimbursed.

To recap

Date ordered or date delivered are both acceptable approaches. However, the plan sponsor must decide which method it chooses to use.

Participants can sometimes get trapped in situations beyond their control and the employer and administrator may review the facts and circumstances and process a claim accordingly.

Flexible Benefit Plans:

IRS Permits Flexibility during Disasters

Jim Snyder, Senior VP, Client Services

FBMC proactively requested and received guidance from the Health and Welfare Branch of the IRS in the wake of six violent hurricanes that pummeled the Gulf Coast and Eastern Seaboard last year. The request for guidance dealt with how to handle enrollment, grace period, missing receipts and other thorny issues when a natural disaster strikes just as one plan year is ending and a new one beginning.

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After extensive deliberation IRS officials authorized FBMC, as the benefit administrator, to take whatever actions reasonably necessary to meet the extenuating circumstances. To the extent that the actions went outside the general rules they were treated as administrative adjustments or changes and documented thoroughly and completely.

We and a few of the clients involved were more than a little concerned that the actions might have a negative impact upon new plan year implementation activities or might confuse customers. After closely monitoring data exchange activities related to payroll and eligibility as well as customer calls during the first quarter of 2005, it appears those concerns were unfounded. The communication and education campaign to notify customers of the special procedures went smoothly and customers were grateful for the special treatment.

For information to those of you who were not impacted by the hurricanes, the actions taken included:

- An extension of the open enrollment period
- A 30-day extension to incur expenses for the previous plan year

Some care providers were destroyed or out of commission for extended periods resulting in missed appointments, delayed procedures, etc.

- Permitting employees whose receipts were destroyed to sign an affidavit indicating so, along with an otherwise completed claim form for reimbursement.
- Permitting employees who were unable to incur day care expenses to receive a refund rather than forfeit funds in their accounts.

Several clients were closed for extensive periods of time and/or day care facilities were destroyed in the storms.

We also contacted all provider companies to assure no customer's coverage lapsed as a result of any delays in forwarding premium payments.

For additional information, contact your Account Manager or Trish Neely.

Reprinted from a previous Quarterly Review

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