

Unfinished Health Care Reform Poses Challenges for January 1 Renewal Season

By: Sue Sieger, CFCI



What we know for sure...

Over 35 million working Americans use employer-sponsored benefit programs like flexible spending accounts (FSA) to help pay for medical, dental and vision expenses. FSAs legally allow pre-tax payroll deductions for qualified expenses, making a portion of payroll tax exempt. FSAs are especially valuable to employees who do not qualify to itemize medical deductions on their own tax returns. Without FSAs... medical, dental and vision care will be more expensive because employees will be using after tax dollars to pay for care. FSAs help employees plan and budget for their medical, dental and vision care and on average will result in an employee payroll tax savings of 25% on FSA deductions.

What we don't know for sure...

If health care reform legislation is finalized this year, what items will make the final cut and when will the changes

become effective? Changes to employer sponsored programs like FSAs and HRAs are looked upon as revenue generators in both the House and the Senate. Proposed changes provide billions of dollars used to balance the health care reform bills.

Potential problems for January 1 renewals...As I write this, the current version of the bill being worked on in the Senate Finance Committee would require a prescription for Over-the-Counter (OTC) medications beginning January

1, 2010. The House version of the bill released at the end of July eliminated OTC as a tax deductible item altogether. **If this portion of health care reform legislation is passed, this will very likely have an impact on FSA election decisions in open enrollment and thereafter.** Whereas, there is no certainty when or if this change would occur, you should urge participants to use caution when estimating annual elections for 2010. It is unlikely that any change to the definition of "qualified medical expense" would allow participants to make an adjustment to their election once the plan year begins. Furthermore, if there is final legislation prior to the end of the year, you may need to communicate any relevant changes to participants and permit them to revise elections already collected before January 1, 2010, for calendar year plans.

Note: Items that are classified as medical equipment (i.e. contact lens solutions, crutches, wheel chairs, bandages, blood pressure monitors, test strips for diabetes, etc.) will **NOT** be impacted by the proposed OTC changes as medical equipment is classified differently under the tax code.

What will health care reform look like when the ink is dry?

The Senate Leadership wants to bring the health care reform bill to the floor during the week of October 12th. In order for that to happen, the Congressional Budget Office (CBO) must agree with the balancing of the bill and the Senate Finance Committee must vote on, and pass, the markup version of the bill. If passed the Senate bill must be merged with the House bills and then it can move onto the floor. The October 12th date may not be realistic considering all that must be accomplished yet.

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Unfinished Health Care Reform Cont.

As of October 6, 2009 the Chairman's Mark includes three problem areas relative to employer sponsored benefits:

1. Capping flexible spending account (FSA) contributions to \$2,500 beginning in 2011. This cap does NOT include an indexing for inflation.
2. Requiring a prescription for certain OTC medications to be eligible for HRA/FSA reimbursement.
3. For purposes of the excise tax calculation, FSAs, HSAs, HRAs, vision, dental and supplemental health benefits are included when determining the value of health benefits against \$8,000 Single and \$21,000 Family limits. Any value of health benefits that exceed the threshold are subject to an excise tax of 40%. The threshold would be used in 2013; however, indexing for inflation will not begin until 2014.

During the Senate Finance Committee debate, the Committee considered key amendments from **Sen. Roberts (R-KS)/Hatch (R-UT); Sen. Roberts (R-KS); Sen. Kyl (R-AZ), and Sen. Ensign (R-NV)**. Although the Committee failed to adopt these amendments related to FSAs and the health benefit threshold amounts, the debate offered Committee Members an opportunity to raise a number of important issues. During debate on the Roberts' amendments, for example, Senator Carper (D-DE) voiced concern about the lack of an index on the FSA cap and asked the Chairman to address the issue prior to the bill going to the floor. The Chairman responded that he appreciated the comment and would work on the issue.

During debate on the Ensign amendment, the Chairman suggested that he would be open to considering an index, but not to increasing the FSA cap. Senator Ensign stated that the index should be medical inflation, not just CPI. Senator Conrad commented that the offset would not likely cover medical inflation. At that point, Senator Ensign requested a vote on his amendment – to increase the cap – which failed. However, at the end of the debate, Senator Schumer (D-NY) raised the same point regarding the lack of an indexing mechanism on the FSA cap and asked the Chairman if he was willing to work to address the issue prior to the bill going to the floor. Chairman Baucus responded yes.

What is next...

Eliminating or capping FSAs for health care expenses and creating an excise tax on health benefits could raise billions of dollars for Congress, but would by default result in a **tax increase to working Americans** and may even result in employees delaying or putting off care altogether. None of this will change the cost of health care.

In an effort to cast a web to catch “Cadillac health plans”, the middle working class will get caught in the same spider web. Employers that have a high population of older workers, workers with families, and workers with chronic medical conditions will find it very difficult to stay under the thresholds set forth in the excise tax calculations. The premiums for this demographic will be higher not because they have a Cadillac plan design, but because of other facts and circumstances that impact the cost. There will be a huge administrative burden associated with tracking the value of health benefits. None of this addresses the cost of care or the change of behavior necessary to have a true impact on health costs. This broad brush approach by Congress will displace more Americans from insurance coverage, as this type of move would make it more and more difficult for employers to be associated with offering employee benefits.

The comments raised by Senators Carper and Schumer, and the response that Chairman Baucus gave are positive signals of interest in fixing the index issue. However, it is very important that Employers and Participants **continue their outreach urging their Senators and Representatives** to let Senate Democratic Leadership know the importance of including an index on FSAs and to reevaluate what is included in the proposed health caps. **Links are available at www.savemyflexplan.org** ■

❄️ ❄️ *Happy Holidays from all of us at Benefits Design Group, Inc.* ❄️ ❄️

COBRA Subsidy Recipients Must Notify the Plan of Other Coverage

[IRS Webpage: COBRA Subsidy Recipients Who Later Become Eligible for Insurance Coverage Should Notify Their Former Employer to Avoid a Penalty Aug. 25, 2009 <http://www.irs.gov/businesses/small/article/0,,id=212421,00.html>

The IRS has posted on its website a reminder that COBRA subsidy recipients who later become eligible for other group health plan coverage or Medicare should notify their plan in writing that they are no longer eligible for the subsidy, in order to avoid a penalty. The IRS webpage explains that if an individual continues to receive the subsidy after he or she is eligible for certain other coverage, such as group health coverage from a new job or Medicare, the individual may be subject to a penalty of 110% of the subsidy provided after he or she became eligible for the other coverage. The reminder includes instructions for individuals to self-report to the IRS that they are subject to the penalty. The IRS also notes that anyone who suspects that someone may be receiving the subsidy after becoming eligible for other coverage may report this to the IRS by completing Form 3949-A (Information Referral). ■

How Do Flex Plans Fit Together With Health Savings Accounts (HSA)?



Just because you add or are considering adding a **HSA compatible** high deductible health plan (HDHP) now or in the future, does not mean that you no longer have use for your Flex Plan. IRS limits on **HSA** annual contributions may not allow employees to set aside enough dollars for their medical, dental and vision expenses. The addition of a **Limited-Purpose Medical FSA** account to your existing Flex Plan may expand your employees' tax deduction possibilities! **Timing is everything!** The timing of when you put the HDHP insurance plans in place; however, can adversely affect the tax deductible status of an employee's **HSA** account. It is recommended that you align your Flex Plan renewal with your health plan renewal or vice versa.

The best time to amend your Flex Plan is at renewal. You can amend your existing Flex Plan to include the new "**HSA compatible**" Limited-Purpose Medical Reimbursement Account and/or add a component to permit the payroll deduction of **HSA** contributions. **HSA** contributions made via payroll deduction offer a convenient way for employees to fund their **HSA** accounts and offers both employers and employees the opportunity to save the additional social security payroll taxes available under the Section 125 tax law for any **HSA** contributions made through the Plan.

Note: Participation in a traditional General-Purpose Medical Reimbursement Account will disqualify an employee from making or receiving **HSA** contributions. Individual employees participating in a "General-Purpose" Medical Reimbursement Account CANNOT convert to the "Limited-Purpose" Medical Reimbursement Account in the middle of a plan year. Adding **HSA** coverage at a time other than the start of the Section 125 Plan Year may leave some employees ineligible to make or receive **HSA** contributions. (Note: It may be possible for the employer to convert the entire plan from General-Purpose Medical to Limited-Purpose Medical in the middle of the Plan Year.) Canceling the Flex Plan altogether in the middle of the running Plan Year, may leave negative balances that an employer cannot collect from participants and balances that may be forfeited by participants who did not incur qualified expenses prior to when the Plan terminated.

Please contact our offices so we can help you review your existing benefit plan, make design recommendations and determine if you will need an amendment to your legal documents before you begin the insurance or Flex Plan renewal process. ■

Medicare Secondary Payer (MSP) Rules

Question:

Do the MSP reporting requirements apply to Health Reimbursement Arrangements (HRA) and Flexible Spending Account (FSA) plans?

Answer:

The MSP reporting requirements **do not apply to health FSAs**.

However, they **will apply to HRAs** beginning with the fourth quarter of 2010.

The MSP rules specify when a group health plan must pay primary and when it may pay secondary if an individual is covered under both a group health plan and Medicare. The rules also provide that employers may not offer individuals entitled to Medicare any financial or other incentives to opt out of employer-provided group health coverage, and they prohibit certain actions that "take into account" an individual's Medicare entitlement.

Responsible reporting entities (RREs) (which include insurers, TPAs, plan administrators, and fiduciaries) will be required to cover HRAs in MSP reporting beginning with files submitted in the fourth quarter of 2010 (October-December 2010). The delayed compliance date was intended to give additional time to gather the necessary information to report on HRA coverage. CMS has indicated that it will provide further instructions on reporting HRA coverage at a later date.

Much of the information that has to be reported to CMS is not commonly collected for HRAs. For example, few HRAs collect Social Security Numbers (SSNs) or other specific information about employees' spouses or other family members. Under the current MSP reporting rules as they apply to group health plans generally, a group health plan must provide CMS with specific information, including SSNs, for all "active covered individuals." In general, an active covered individual is someone who may be Medicare eligible and currently is employed, or the employee's spouse or other family member who is covered by the employee's group health plan and who may be eligible for Medicare. Various age and other requirements also apply.

TPAs (or Employers self administering HRAs) must begin transmitting eligibility details about HRA participants that will include (but not limited to) the names and social security numbers of spouses and dependents covered under HRA arrangements. This information will be gathered as HRA plans come up for renewal.

There are significant penalties for failure to comply with the MSP reporting requirements. RREs that fail to comply are subject to a civil monetary penalty of \$1,000 for each day of noncompliance for each individual for whom information should have been submitted to CMS. This penalty is in addition to any other penalties prescribed by law and any potential claims under the MSP regulations (e.g., a claim by Medicare that the group health plan should have paid primary to Medicare). ■

CMS HICN/SSN Form for Mandatory Reporting

[MMSEA 111 - HICN/SSN Collection - GHP Model Language Form (Aug. 18, 2009)]

For a copy: <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf>

In May 2009, CMS issued compliance guidance and model language to assist responsible reporting entities (RREs) in obtaining Medicare Health Insurance Claim Numbers (HICN) or Social Security Number (SSN) information from Medicare beneficiaries for mandatory reporting purposes.

The model language prompts individuals to provide HICN or SSN information, but also provides a space for them to explain their refusal to provide the information, below their acknowledgment that noncompliant Medicare beneficiaries may be in violation of the MSP rules. Under a safe harbor, if an individual refuses to furnish a HICN or SSN, and the RRE uses the optional model language, the RRE will be compliant for its next file submission to CMS if it (1) obtains a signed copy from the individual of the model language in the format provided, (2) has the model language (with the picture of the Medicare ID card) re-signed and dated at least once every 12 months, and (3) retains the documentation. ■

STAFF NEWS

Promotions and New Designations Awarded

We have a few staffing announcements! **Kimberly Ness**, CFCI, who has been with our organization for over fourteen years, has recently been promoted to Operations Manager of Benefits Design Group, Inc. Her contact with clients will not change; however, we feel that this new title is more representative of the additional organizational duties that she is involved with concerning day to day operations. We congratulate her and recognize her as a valuable asset of our organization. In addition, as a result of her attendance at the Employer's Council on Flexible Compensation (ECFC) Flexible Benefit Plan Administrator's Symposium held in St. Paul this summer, she has upgraded her designation with the ECFC to "Certified in Flexible Compensation Instruction (CFCI)". She now joins General Manager **Sue Sieger**, CFCI with the instructor designation.

Brenda Manke, CFC has been awarded the highest professional certification available for practitioners in flexible compensation by the Employer's Council on Flexible Compensation (ECFC). **Brenda Manke** has been "Certified in Flexible Compensation" by the Council's Academy for Professional and Ethical Standards. She joins **Shawn Bresnahan**, CFC, Employee Benefits Consultant of our Wausau location who obtained his designation in 2005.

The designations are awarded as a result of a rigorous examination covering plan design and administration, the law, regulations and ethical standards. The examination covered flexible benefit programs, including flexible spending accounts, child and elder care reimbursement accounts, Health Reimbursement Arrangements (HRA), Health Savings Accounts (HSA), 401(k) and other defined contribution plans and innovative forms of compensation and benefits. Their achievements put them among the elite few hundred that have been awarded these designations nationwide and it demonstrates the continued commitment that Benefits Design Group, Inc. has to be leaders in employee benefit plan administration. ■

HOLIDAY SCHEDULE

We will be closed in observance of the following holidays:

Thanksgiving



There will only be one Service Option #1 check process this week on Tuesday.

Wednesday, November 25, 2009 close early at 1pm

Thursday and Friday, November 26 and 27, 2009 closed all day



Christmas

There will only be one Service Option #1 check process this week on Tuesday.

Thursday, December 24, 2009 and Friday, December 25, 2009 closed all day.

New Years Day

Friday, January 1, 2010 closed all day.

Normal office hours

7:30 a.m. - 4:30 p.m. M-TH, 7:30 a.m. - 1:00 p.m. F (CST)

Employees may access their account information 24/7 at: www.bdgflex.com ■



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DOL Releases New FAQs On All-Electronic Form 5500 Filing Under Efast2

Available at: <http://www.dol.gov/ebsa/faqs/faq-EFAST2.html>

Form 5500 Annual Return/Report of Employee Benefit Plan
OMB No. 1210-0110 / 1210-0089
2008
This Form is Open to Public Inspection.

Part I Annual Report Identification Information
For the calendar plan year 2008 or fiscal plan year beginning [MM/DD/YYYY] and ending [MM/DD/YYYY]

A. This return/report is for: (1) a multiemployer plan; (2) a multiple-employer plan; or (3) a DFE (specify) _____

B. This return/report is: (1) the first return/report filed for the plan; (2) the final return/report for the plan; (3) an amended return/report; (4) a short plan year return/report (less than 12 months).

C. If the plan is a collectively bargained plan, check here _____

D. If filing under an extension of time or the DFVC program, check box and attach requested information. (see instructions) _____

Part II Basic Plan Information -- enter all requested information.

1a Name of plan _____

1b Three-digit plan number (PIN) ▶ _____ 1c Effective date of plan [MM/DD/YYYY]

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

Signature of plan administrator _____ Date [MM/DD/YYYY]

SIGN HERE ▶ _____

Type or print name of individual signing as plan administrator

a Signature of employer/plan sponsor/DFE _____ Date [MM/DD/YYYY]

SIGN HERE ▶ _____

Type or print name of individual signing as employer, plan sponsor or DFE

b _____

For Paperwork Reduction Act Notice and OMB Control Numbers, see the Instructions for Form 5500. Cat. No. 13500F Form 5500 (2008)

1 0 1 0 8 0 0 0 1 0 A v11.3

All Form 5500s must be filed electronically for plan years beginning on or after January 1, 2009. Health Reimbursement Arrangements (HRA) and Medical Flexible Spending Account (FSA) plans that are subject to Form 5500 filing requirements because of participation size or funding method will need to get ready to file electronically. Paper filing will no longer be an option. Forms are generally due by the last day of the seventh month following the end of the plan year. Therefore, the first time plan sponsors will need to begin electronic filing will likely be by July 2010 for the 2009 plan year.

The DOL's EFAST website now contains 45 FAQs addressing EFAST2, the all-electronic filing system for Form 5500 that is scheduled to be available beginning January 2010. Summary of some of the FAQs as followed:

- Q/A-3:** 2009 short plan-year filers whose filing due date is before January 1, 2010 will receive an automatic extension to electronically file their Form 5500 within 90 days after the EFAST2 system is available on the DOL's website.
- Q/A-7:** DOL is compiling a list of commercial vendors that have developed "approved software" for use in preparing and submitting Form 5500s under EFAST2. There are separate certifications available for preparing filings and another for submitting them.
- Q/A-8:** Advantages of using EFAST2-approved third-party software instead of IFILE, the DOL's free ("no frills") filing system. Third party software can file batches of forms vs. IFILE that is limited to single filings.
- Q/A-19:** How to see what a Form 5500 will look like before it is filed.
- Q/A-20:** How to export a draft Form 5500 for review by others.
- Q/A-21:** Checking for errors prior to submission--a process called "validation".
- Q/A-30:** How a service provider transmits a filing to the plan sponsor/administrator for electronic signature.
- Q/A-32:** Confirms that electronic signing credentials cannot be obtained for clients by third-party preparers.

The DOL also notes on the webpage that EFAST2 electronic credentials must be obtained in order to sign and/or submit Form 5500 (or to prepare Form 5500 in IFILE). Beginning January 2010, these credentials can be obtained by registering on the EFAST website (www.efast.dol.gov).

To help with this transition, the DOL has presented two webcasts on 2009 Form 5500 using EFAST2, both of which are also available on the EFAST website. Among the topics addressed in these webcasts is the process for registering for electronic credentials, through which the user ID, pin, and password used to sign and transmit a completed Form 5500 to EFAST2 can be obtained. We will continue to update clients as information becomes available. ■

We're Wired!!!



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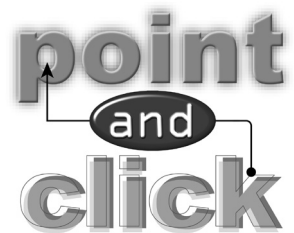
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about the tax law.

Check out what's new
in benefits.

OR

Download our
current forms.

Just



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This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that neither the author nor the publisher is engaged in rendering legal, accounting or other professional service. If legal advice or other expert assistance is required, legal counsel should be consulted.

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