Commercial Insurance Update

Topics Affecting Buyers of Commercial Insurance

MSP C 08/2005 – "Soften the Blow of Rising Health Care Costs" August, 2005

Soften the Blow of Rising Health Care Costs

Article courtesy of MyWave

Choose the Employee Health Plan Option That's Best for *Your* Business

Employers are increasingly looking to consumer-driven health plans to help soften the blow of continually rising healthcare costs. Depending on the model, these plans typically include **Medical Savings Accounts (MSAs)**, **Health Reimbursement Arrangements (HRAs)**, **Flexible Spending Accounts (FSAs)**, and most recently, **Health Savings Accounts (HSAs)**.

Some plans allow employees to use these accounts to pay for medical expenses that are not covered by insurance, while employers use others to provide employees with a fixed dollar amount with which they can purchase healthcare services or a health insurance policy on the open market.

The explosion of these types of plans — or at least the explosion of discussion about these types of plans as a potential cure for rising healthcare costs — has left many consumers and employers confused about the right approach.

This article provides some basic information about the similarities and differences between MSAs, HSAs, HRAs, and FSAs.

Medical Savings Accounts

Medical Savings Accounts (MSAs) were authorized under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Perhaps the original consumer-driven health plan, the **Archer MSA** is an account that allows year-to-year rollovers and is designed to be combined with a high-deductible health insurance policy. The high deductible policy protects the insured from catastrophic loss, such as a prolonged illness or hospitalization, or simply an unexpected period of poor health. The savings account is controlled by the individual, and is intended to pay for routine healthcare services.

Congress simultaneously imposed on Archer MSAs several restrictions that reduce their practicality and appeal to employers and employees. For example, tax-free MSAs are only available to the

Health Care Costs *(Continued on page 2)*

In this issue...

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Health Care Costs *(Continued from page 1)*

self-employed and the employees of small businesses (under 50 employees).

Larger and medium-sized employers and employees of companies that do not provide health insurance are not eligible for an Archer MSA. These individuals may be eligible for a non-qualified MSA plan, but the nonqualified plans provide no Federal tax break.

Another downside to the Archer MSA is that the employer and employee may not both contribute to the employee's MSA in the same year.

The MSA pilot program will expire on December 31, 2005. While MSA accounts established prior to this date may continue to be used and receive contributions, no new accounts may be established after December 2005.

Health Savings Accounts

In December 2003, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 established a new type of tax-favored **Health Savings Account (HSA)**. HSAs are much like MSAs, but the rules applicable to HSAs are less restrictive.

An individual that is (1) covered by a high deductible health plan, (2) does not have other health insurance coverage (with some exceptions), and (3) is not claimed as a dependent on another person's tax return may establish an HSA.

An HSA may be established by an individual, including the self-employed, or may be employer sponsored. Unlike MSAs, the employer and employee can contribute to the HSA in the same year, subject to annual limits.

Like the MSA, the high deductible health plan is designed to protect the individual against catastrophic loss, but allows the individual to roll over unspent funds in the HSA from year to year. Since the HSA is a tax-exempt trust owned by the individual, employees take the account with them upon termination or retirement.

IRS guidance has many of the questions benefit experts were raising related to the use of HSAs since their inception in January 2004. Because of this, carriers have been able to create successful products to work in conjunction with an HSA.

Flexible Spending Accounts

In 1986, the Internal Revenue Code Section 125 introduced the **Flexible Spending Account (FSA)**. FSAs provide a means for employees to considerably reduce their income tax liability through salary reduction. Employees can contribute a portion of their own salary to an account designated to pay for healthcare expenses. These pre-tax contributions are exempt from income and payroll taxes.

Several inherent design flaws have resulted in modest participation in FSAs. Tax code requires that only employers set up these accounts for their employees, leaving self-employed individuals and millions of other employees unable to set up their own accounts.

In addition, the *"use-it-or-lose-it"* provision within the FSA has been its biggest downside. Employees are required to elect a specific amount of salary deduction at the beginning of the year, and then have to use every dollar in the account by the end of that year. Because annual medical expenses are hard to predict, employees often over-fund their accounts and then spend unnecessarily at the end of the year to avoid forfeiting the money in their accounts.

Legislation that proposed to allow participants to carry over $500 from the prior year did not pass

Health Care Costs *(Continued on page 3)*

Health Care Costs *(Continued from page 2)*

in 2003 as expected. This change would have built more consumerism into the use of FSAs. However, a recent change has been approved that allows a 2-1/2 month grace period in Section 125 FSAs. Although the *"use it or lose it"* rule still applies, employees will now have 14-1/2 months to spend the money instead of only 12. (See *"Welcome News for Flexible Spending Accounts: Grace Periods Allowed!"* on page __ of this issue for more information.)

Critics of FSAs also note that they are difficult and confusing to set up and administer, causing many small and midsize employers without adequate resources to forego their use. In addition, filing claims for reimbursement can sometimes be difficult and time consuming for the employee.

Health Reimbursement Arrangements

In June 2002, the IRS confirmed that funds within a **Health Reimbursement Arrangement (HRA)** may be rolled over from year to year. HRAs allow employees to use employer contributions only for medical expenses or to pay health insurance premiums.

Unlike FSAs in the past, unused HRA balances may accumulate from year to year, thus providing a personal stake for the consumer in the financial outcome of his or her healthcare spending decisions.

Because HRAs are group health plans, they are subject to laws such as HIPAA and COBRA. If an employee leaves an employer, he may continue to access unused funds within the HRA by electing COBRA. Under COBRA, the employer may also be required to continue its contributions during the COBRA coverage period. The requirement to continue contributions and comply with HIPAA is a deterrent for employers to implement an HRA.

What's the Right Approach for Your Business?

Introducing consumerism into your health plan requires an evaluation of the benefits and disadvantages of Medical Savings Accounts, Health Savings Accounts, Flexible Spending Accounts, and Health Reimbursement Arrangements. No one solution is right for every employer. In light of the complexities of choosing the right consumer-driven health plan, many employers continue to take a wait-and-see approach.

Disclaimer: *All articles are written from an insurance perspective and are meant to be used for informational purposes only. It is not the intent of any article to provide legal advice, or advice for any specific fact, situation or circumstance. Contact legal counsel for specific advice.*

Welcome News for Section 125 Plans: Grace Period Allowed!

Article courtesy of MyWave

Internal Revenue Code Section 125 allows employees to make pre-tax contributions to a **Flexible Spending Account (FSA)**. Employees may seek reimbursement from the FSA for expenses paid for child care and eligible medical expenses not otherwise covered under a health insurance plan.

FSAs are subject to the "use-it-or-lose-it" rule. Thus, any money remaining in the FSA at the end of the Section 125 plan year must be forfeited. For several years, Congress has declined to pass proposed legislation that would allow employees to carry over unused funds within an FSA.

On May 18, 2005, the Treasury Department and the IRS released Notice 2005-42 (Notice). This notice allows Section 125 Plans, including FSAs, to allow a grace period during which plan participants may continue to incur eligible medical expenses.

When may employers permit grace periods within their Section 125 Plans?

At the employer's option, it may allow grace periods within its Section 125 Plan beginning with the current plan year, so long as the plan document is amended before the end of the current plan year.

Grace Period *(Continued on page 4)*

Grace Period *(Continued from page 3)*

How long is the grace period?

The Notice states that *"the grace period must not extend beyond the fifteenth day of the third calendar month after the end of the immediately preceding plan year to which it relates."* In other words, employers may add a 2-½ month grace period to the end of their Section 125 Plan year.

For example, a plan with a plan year ending on December 31, 2005 may allow plan participants to continue to incur expenses through March 15, 2006.

The grace period must apply to all participants in the Section 125 Plan.

How does a grace period differ from a "run-out" period?

A **grace period** extends the amount of time in which participants may incur expenses.

A **run-out period** allows employees to submit eligible expenses after the close of the plan year. Unlike a grace period, expenses submitted during the run-out period must have been incurred prior to the end of the plan year (including grace period).

Plans that choose to allow a grace period within its Section 125 Plan should also consider amending their plan to allow the run-out period to begin on the last day of the grace period.

Comparison of Tax-Advantaged Health Care Options

Table courtesy of MyWave

***For calendar year 2005**

FAQs	HSA	MSA	FSA	HRA
Name of account	Health Savings Account	Medical Savings Account	Health Flexible Spending Account	Health Reimbursement Arrangement
Who owns the account?	Individual/employee	Individual/employee	Individual/employee	Employer
Who may fund the account?	Employer or employee, can be both in the same year Employee can contribute pre-tax dollars through Section 125 plan	Employer or employee, but not both in the same year Must be small employer or self-employed individual	Employer/employee Typically the employee contributes pre-tax dollars through a Section 125 plan	Employer Self-employed individuals, including partners, and more than 2% shareholders in a subchapter S-Corporation cannot contribute
What plans may be offered with the tax-advantaged account?	A HDHP as follows*: Min. Deductible $1,000 I $2,000 F OPM $5,100 I $10,200 F	A HDHP as follows*: Min. Deductible $1,750 I $3,500 F Max. Deductible $2,650 I $5,250 F OPM $3,500 I $6,450 F	Any or no health plan	Any or no health plan
Is there a limit on the amount that can be contributed per year?	Lesser of*: *100% of deductible *$2,650 I $5,250 F Catch-up contributions: $600/year – age 55 by end of tax year Reduced by MSA contributions in same year	**65% of individual deductible* **75% of family deductible*	No, there is no IRS prescribed limit	No, there is no IRS prescribed limit
Does the uniform coverage rule apply?	No	No	Yes	No

Comparison *(Continued on page 5)*

Comparison *(Continued on page 5)*

For calendar year 2005.

FAQs	HSA	MSA	FSA	HRA
Can unused funds be rolled over from year to year?	Yes	Yes	No, although in some cases employee may elect COBRA through end of plan year A recently approved 2-1/2 month grace period allows Plan members to take up to 14-1/2 (rather than 12) months to use the money (see *"Welcome News for Section 125 Plans: Grace Period Allowed!"* article on page 3)	Yes, subject to COBRA
What expenses are eligible for reimbursement?	Section 213(d) medical expenses **COBRA premiums* **QLTC premiums* **Health premiums while receiving unemployment benefits* **If Medicare eligible due to age, health insurance premiums except medical supplement policies*	Section 213(d) medical expenses **COBRA premiums* **QLTC premiums* **Health premiums while receiving unemployment benefits*	Section 213(d) medical expenses Expenses for insurance premiums are not reimbursable Employer can define "eligible medical expenses"	Section 213(d) medical expenses **Health insurance premiums for current employees, retirees, and qualified beneficiaries, and QLTC premiums* Employer can define "eligible medical expenses"
Must claims submitted for reimbursement be substantiated?	No	Yes	Yes	Yes
May account reimburse non-medical expenses?	Yes, but taxed as income and 10% penalty (no penalty if distributed after death, disability, or eligible for Medicare)	Yes, but taxed as income and 15% penalty; no penalty if after age 65	No	No
Is interest earned on the tax-advantaged account?	Yes, accrues tax-free	Yes, accrues tax-free	No	Yes, paid to the employer

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2005 Changes in Qualified Retirement Plans

Article courtesy of MyWave

Qualified Retirement Plans must take various dollar limits into consideration. Some of these are indexed and can therefore change on occasion. Below are the changes for 2005, as well as the figures for 2004.

Determination of Highly Compensated Employees

1. Employees owning more than 5% of a company, as well as an employee who is a spouse, child, parent or grandparent of an employee owning more than 5% of a company will always be considered highly compensated.
2. Employees who earned more than $95,000 in 2005 will be considered highly compensated in the following year.

Limits	2005	2004
401(k) Contribution Limit (Calendar Year)	$14,000	$13,000
401(k) Catch-up Contribution Limit	4,000	3,000
Annual Contribution Limit (Money Purchase, Profit Sharing, Target Plans)	42,000	41,000
Annual Benefit Limit (Defined Benefit Plans)	170,000	165,000
Plan Compensation Limit	210,000	205,000
Social Security Wage Base	90,000	87,900

FAQs about AB 2208

Same Sex, Registered Domestic Partners

We've been asked a number of questions about AB 2208, a California law that deals with ***same sex, registered*** domestic partners. The bullet points answer the most common questions.

- California State law AB 2208 went into effect on January 2, 2005. All plans that qualify as "group health plans" made the change on that date. However, if a group's health policy renewed on January 1, 2005, the group will be exempt from the change until its next renewal in 2006. All other plans that don't qualify as "group health plans" renewed with the change (these include life and disability plans).
- The term "Registered Domestic Partner" refers to ***same sex*** domestic partners (unless one or both are over age 62, in which case it can apply to partners of the opposite sex)
- Employers ***must*** offer coverage to Registered Domestic Partners if they are active under the new law (determined by policy renewal date – see first bullet point)
- Groups have a fiduciary responsibility to inform all group members of any new laws that effect their coverage; therefore, employers must notify employees of their ability to add Registered Domestic Partners to the plan.
- If employers request documentation for proof of a Registered Domestic Partner, they also have to ask for documentation for married spouses – this does not have to be a retroactive request.
- No COBRA will be given to a Registered Domestic Partner that loses coverage.
- Groups based out of state ***do not*** have to honor AB 2208 for their California employees.
- Any group that wants to add the Registered Domestic Partner coverage option to its plan prior to the policy renewal (at which time it will be added automatically) may do so. The group just has to ask its insurance carrier to add the contract language to the group's policy.

Note: Registered Domestic Partner premiums are ***not*** eligible for pre-tax deductions. When doing payroll, all affected employers must denote premium for a single person (not the difference between a single and a single + dependent), and it must be deducted after tax for the Registered Domestic Partner.