

In This Issue

In this final issue of the McGraw Wentworth Benefit Advisor for 2001, we will review a year-end checklist for employee benefit programs. This review will include topics such as legislative compliance, taxable consequences of group term life insurance, W-2 filing requirements for disability payments, Medicare costs and the 2002 indexed plan limits.

Each Benefit Advisor is designed to:

- *Provide information on specific technical, tax or legislative issues affecting employee benefit plans.*
- *Offer analysis as to the impact that those issues have on your plans.*
- *Establish the framework for us to work with you in determining the action steps necessary to bring your plans into compliance.*

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit our web site at www.mcgrawwentworth.com.

“Year 2001 Year-End Checklist”

PRIORITIES FOR GROUP BENEFIT PROFESSIONALS

Employee benefit plan sponsors have a number of reporting, disclosure and testing requirements that must be addressed each calendar year.

This technical bulletin is designed to serve as a reminder of these requirements and to provide you with information regarding updates to specific benefit

limitations and regulations for 2002.

Group Term Life Insurance Imputed Income

Section 79 of the Internal Revenue Code requires employers to report imputed income on the value of company-paid life insurance benefits in excess of \$50,000. Section 79 also has tax implications for company-paid Group Term Life insurance plans if the plan discriminates in favor of key employees.

If you provide company-paid life insurance over \$50,000 for any employees or if you offer a company-paid Group Term Life plan that discriminates in favor of key employees, you must calculate the imputed income or value of the excess coverage. The imputed income value

of the life insurance needs to be added as taxable income to each affected employee's paycheck.



The calculation of imputed income for non-discriminatory plans and for non-key employees covered under discriminatory plans is based upon Table I rates. For key employees in a discrimina-

tory plan, the calculation also requires a copy of the insurer's table of premium rates, which is used to determine the group composite rate. You will need to perform several calculations on this rate table to determine if the actual cost is greater than the Table I rates. Please review Volume Four, Issue Nine of our Benefit Advisor for more information regarding Section 79 and how to calculate any necessary imputed income based on your group life plan's provisions.

Effective July 1, 1999, the IRS issued new regulations revising Section 79, Table I rates. The new regulations modified the Table I rates and provided guidance to employers that offer Group Term Life insurance to their employees. There were three key changes based on the new regulations. They were as follows:

- Lowered uniform rate schedule in all age brackets of Table I
- Added age bracket to Table I
- Increased potential to create taxable income for employee paid plans even when they are paid with after-tax earnings

Those changes were effective July 1, 1999. Employers did, however, have until the last pay period of 1999 to make the following adjustments:

- Change the amounts withheld for FICA purposes
- Reprogram payroll systems to accommodate the new age bracket

Please refer to Volume Four, Issue Nine of our Benefit Advisor for information regarding the changes to Table I that went into effect July 1, 1999. At this point the changes to the amounts withheld and to the payroll systems should have been made.

2002 Medicare Information

The 2002 Medicare Part A deductible and copays and Part B premium and deductible amounts are listed in the chart below.

Age Bracket	New Table 1 - Cost per \$1000	Old Table 1 - Cost per \$1000
Under 25 <small>(new bracket, was combined as under 30)</small>	\$0.05	\$0.08
25 to 29	\$0.06	\$0.08
30 to 34	\$0.08	\$0.09
35 to 39	\$0.09	\$0.11
40 to 44	\$0.10	\$0.17
45 to 49	\$0.15	\$0.29
50 to 54	\$0.23	\$0.48
55 to 59	\$0.43	\$0.75
60 to 64	\$0.66	\$1.17
65 to 69	\$1.27	\$2.10
70 and above	\$2.06	\$3.76

Short Term Disability W-2 Forms

If you offer a company-paid short-term disability plan, W-2s need to be issued for all employees who received benefits under the plan in 2001.

Some short-term disability insurance carriers and administrators will issue W-2s directly to claimants who had claims during the year. However, many carriers and administrators provide you with a quarterly or annual report including the information necessary to issue each

employee's W-2. Check with your short-term disability carrier or administrator to determine how they handle W-2 issuance. If you are responsible for issuing the W-2, make sure your payroll vendor is aware that each disability claimant will have additional compensation that will need to be included on the W-2.

Legislative Compliance

You need to be aware of several pieces of legislation you will need to comply with during Year 2002.

Mid-Year Elections Section 125 Revised

On March 23, 2000, the IRS issued final and proposed regulations concerning mid-year election changes for cafeteria plans. The final regulations went into effect for plan years beginning on or after January 1, 2001. The new regulations provided for clearer guidance and greater administrative flexibility when it comes to mid-year elections.

Continued on Page 3

MEDICARE INFORMATION

Medicare Part A Deductible	\$812
Hospital Per Day Copay	
60 to 90 day stays	\$203
90 + day stays	\$406
Skilled Nursing Facility Per Day Copay (after 20 days)	\$102
Medicare Part B Premium	\$54
Medicare Part B Deductible	\$100

On August 17, 2000 the IRS and Treasury held a public hearing after receiving written comments regarding the March 23, 2000 final and proposed regulations. Based on the comments made at the hearing, the final and proposed regulations were revised.

Final Regulations

The final regulations provided a detailed list of the events that trigger permissible mid-year changes in an employee's election of cafeteria plans. The event specifically affected by the 2001 changes is:

- **Change in Legal Marital Status - Changes in coverage requirements on account of marriage, death of spouse, divorce, legal separation or annulment.** *The 2001 changes extend the ability to change the coverage due to the change in marital status (or employment status) to include birth, adoption, placement for adoption or death.*

The "status change events" were to be applied according to a consistency rule, which stated that any change in benefit elections was to be consistent with the status change event which occurred. This rule was modified based on the August hearing. In addition, the August hearing led to a modification to the March 2000 final regulations which allowed for participants to either increase or decrease life and/or disability coverage due to any of the change events listed.



The 2001 changes expanded upon the rule and required that the election change be consistent with the status change affecting eligibility for an employer's plan and includes a change in status resulting in an increase or decrease in the number of an employee's family members or dependents who benefit from plan coverage.

Another change event affected by the 2001 changes is:

- **Domestic Relations Order or Qualified Medical Child Support Order:** *When a divorce, legal separation, annulment or change in legal custody occurs, cafeteria plan changes are permitted to conform with the domestic relations judgment, decree or order or qualified medical child support order. The 2001 changes permit the employee to change their election only if the former spouse or other individual actually provides the coverage to the employee's child.*

Proposed Regulations

At the same time the now final regulations were issued, new proposed regulations were also issued. Until they become effective, the new proposed or previously proposed regulations may be relied upon. The new proposed regulations apply the status change events not only to health and life insurance coverages (as in the final regulations) but also to all qualified cafeteria plan benefits. The proposed regulations also outline when mid-year elections may be made due to

plan cost and coverage changes as follows:

- **Changes in Cost:** *If the cost of a plan benefit increases or decreases, affecting the employee contributions, these changes in contributions can be made automatically. Modifications also allow changes when there is a "significant" decrease in the cost of the benefit option package. If there is a significant decrease or increase in the cost of the benefit option package during the plan year, the cafeteria plan may allow all employees, even those who have not previously participated in the cafeteria plan, to elect to participate.*
- **Changes in Coverage:** *Mid-year changes are permitted in the case of significant changes in coverage (i.e., coverage is curtailed or increased). Additional clarification and modifications have been made in 2001 to allow for employees to drop coverage if there is no similar coverage offered when there is a change that constitutes a loss of coverage such as: complete loss of coverage (HMO not located where employee resides).*

Elections may also be revised if a benefit option package is added or eliminated mid-year. The 2001 changes permit the election to be made by any employee whether they have made an election previously or not. In addition, like the adjustments made to the changes in cost rule, the changes in coverage rule is expanded to all qualified benefits, except for health FSA elections. This means that new dependent care elections can be

made to reflect a change in dependent care providers.

- **Change in Coverage Under Other Employer's Plan:** Employees may make election changes mid-year if there is a corresponding open enrollment change made by a spouse or dependent whose plan year is different from that of the employee. The 2001 final regulations expand the rule to any employer plan, whether the employer is the same or different.
- **Dependent Care Change in Status:** The proposed regulations do not create special changes for dependent care FSAs but clarify that changes in cost and coverage permit changes to dependent care FSA elections under certain circumstances.
- **Employer Initiated Changes:** Employees can change their cafeteria plan elections even if a third party did not initiate the changes to the plan's cost or coverage.

With the August 2000 modifications comes additional effective dates. The 2001 changes to the final regulations (with the exception of the judgment, decree or order provision to be effective with plan years beginning on or after January 1, 2002) went into effect with plan years beginning on or after January 1, 2001 while the proposed regulations are applicable with cafeteria plan years beginning on or after January 1, 2002. Until that time, the March 2000 regulations can be relied upon.



For more details, please review Volume Four, Issue Five of our Benefit Advisor.

New ERISA Claims Rules

On November 21, 2000, the Department of Labor published final regulations that revise the claim regulations first adopted under ERISA in 1977. The regulations were to be effective January 20, 2001, but only apply to claims filed on or after January 1, 2002. The regulations have since been revised as follows:

- **Extension for ERISA group health claims**
 - *Calendar year group health plans: requirements first apply to claims filed on or after January 1, 2003*
 - *Other group health plans: requirements first apply on the first day of the plan year beginning on or after July 1, 2002*
- **No extension for disability or other ERISA claims**

The Claim Filing & Review Regulations require new claims filing and appeal procedures for group health and disability plans. According to the Department of Labor, the rules are designed to ensure that group health plan participants (mostly in the managed care environment) "have access to a faster, fairer, fuller process for benefits determinations."

The major focus of the new regulations is on the time with which claims are processed. The new regulations revise the previous 90-day decision process and shorten the time frames to the following:

- **Urgent care claims** (claims for care which is considered necessary to preserve the life, health or ability of the patient giving him or her maximum function or for which a delay of treatment would have caused the patient severe pain): 72 hours
- **Pre-service claims** (approval of benefit prior to obtaining the medical care): 15 days with one 15 day extension available
- **Post-service claims:** 30 days with one 15 day extension available

The regulations also require faster resolution of denied claims as follows:

- **Urgent care claims:** 72 hours
- **Pre-service claims:** 30 days
- **Post-service claims:** 60 days
- **Disability claims:** 45 days with one 45 day extension for appeals

In addition to changes in time frames for claims review and processing, there are new guidelines as to specific items that must be included in or as a part of the review process:

- **Notices of initial benefit determinations and decisions on review must now include the rules, guidelines, protocols and other information that were relied on to make the determination or the denial (if it was based on medical necessity, experimental treatment or similar exclusion, explanation of scientific or clinical judgment), as well as the identity of the medical or vocational experts consulted**
- **Access to all documents, records and other information relevant**

- to the benefit determination must be provided free of charge*
- *Claim appeals may not be conducted by the same person who made the original decision*
 - *If an appeal involves medical judgment, a healthcare professional must be consulted*
 - *If benefits are about to be reduced, participants receiving ongoing treatment for the benefits being reduced or terminated must be notified of the upcoming change*
 - *Participants have 180 days to file an appeal (as opposed to the previous 60 days)*

As mentioned earlier, these rules were to be effective January 20, 2001 and only affect claims filed on or after January 1, 2002. The regulations have been revised and extended for ERISA group health claims (a year extension for calendar year plans to be effective January 1, 2003 or an effective date of July 1, 2002 or later for all other group health claims). All plan documents affected by these changes will have to be made by plan sponsors and reflected in the plan documents. HMOs will no longer be exempt from the changes and group health and disability plans will have to implement the changes both in their documentation and in their administrative procedures.

HIPAA Electronic Transaction Standards

On August 17, 2000, the Department

of Health and Human Services published the final Health Insurance Portability and Accountability Act (HIPAA) rules concerning administrative simplification and electronic transaction standards. The final regulations outline requirements for health care providers, health plans and health care clearinghouses as they relate to the electronic exchange of information and data. The new rules streamline health care claims processing, reduce paperwork, save money for all involved in the health care system and improve service for providers and patients alike.

Originally, all parties affected by the new rules were to comply with the final regulations by October 16, 2002 (small health plans [annual receipts of \$5 million or less] to comply by October 16, 2003).

On December 13, 2001, the United States Senate passed the House version of the Transactions Delay Bill, which enables those entities covered under the electronic transactions standards rules to delay their compliance with the regulations.

With the passage of the Transactions Delay Bill, compliance is delayed by one year to October 16, 2003 if a compliance plan is submitted to the Secretary of the DHHS by the original deadline of October 16, 2002. The compliance plan must include a

budget, schedule, work plan and strategy for achieving compliance.

For more details, please review Volume Four, Issue Three of our Benefit Advisor.

New Final and Proposed COBRA regulations

Passed in 1999, the new regulations were effective with qualifying events occurring in plan years beginning on or after January 1, 2000.

For more details and a comparison of the previous regulations ver-

sus the new regulations, please review Volume Four, Issue Five and Volume Three, Issue Four of our Benefit Advisor.

The Women's Health and Cancer Rights Act of 1998

Passed October 21, 1998 (commonly referred to as "Janet's Law"), the Act requires medical plans (employer-sponsored, insured or self-funded, HMO plans and individual health plans) to provide specific benefits to women following a mastectomy. The required coverage includes services related to reconstructive surgery following a mastectomy. Employers and carriers were required to comply with the law effective the first plan year beginning on or after October 21, 1998.

It is important to remember this law requires that employers provide every group plan participant and beneficiary with an annual notice stating the post-mastectomy coverage is available under the plan. The notice is required



Notable Thoughts

**A WISE MAN WILL MAKE MORE OPPORTUNITIES
THAN HE FINDS.**

FRANCIS BACON (1561-1626)

Continued on Page 6

regardless of whether or not the plan provided the benefits required by this law prior to the law being passed. The notice may be provided with open enrollment materials. This portion of the law went into effect beginning with the next employer mailing on or before January 1, 1999.

For more details, please review Volume One, Issue Nine of our Benefit Advisor.

2002 Indexed Plan Limits

The table below summarizes the 2002 indexed plan limits. Please note that limitations for retirement plans for 2002 reflect the recently passed Economic Growth and Tax Relief Reconciliation Act (EGTRRA) of 2001. The FICA taxable wage base will increase from \$80,400 in 2001 to \$84,900 in 2002. **MW**

INDEXED PLAN LIMITS

PLAN LIMITS	2001	2002
Section 401(k) or SAR-SBP	\$10,500	\$11,000
Section 402(g) maximum pre-tax contribution by employees for elective deferrals	\$10,500	\$11,000
Section 403(b) Plan	\$10,500	\$11,000
Section 408(p)(2)(A)SIMPLE Plan Contributions	\$6,500	\$7,000
Section 457(b)(2) Limit	\$8,500	\$11,000
Section 415 Limit for:		
Defined Contribution Plans (calendar year)	\$35,000	\$40,000
Defined Contribution Plans (non-calendar year)	\$35,000	\$35,000
Defined Benefit Plans	\$140,000	\$160,000
Highly Compensated Employees		
Section 414(q)	\$85,000	\$90,000
Includible Compensation - Section 401(a)(17)	\$170,000	\$200,000
Annual Excess Distributions-Section 4980(c)(1)(b)	N/A	N/A
FICA Taxable Wage Base		
Social Security (Tax Rate 6.2%)	\$80,400	\$84,900
Medicare (Tax Rate 1.45%)	No Limit	No Limit

Our technical bulletins are written and produced by the McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Consult your legal counsel or tax advisor in matters that directly affect your benefit plans.

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