



BENEFIT *Advisor*

In This Issue

In this final issue of the McGrawWentworth Benefit Advisor for 2007, we review the important developments that affected employee benefit programs throughout the year. We will also review the year-end housekeeping issues that organizations should revisit annually.

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 the McGrawWentworth web site at www.mcgrawwentworth.com.

“2007 Year-End Review”

The government was busy releasing guidance in 2007. For the most part, many of the new rules clarified previously issued guidelines. Below is a summary of the key areas clarified for 2007:

- Many issues relating to Health Savings Accounts.
- Final HIPAA non-discrimination rules.
- HIPAA Security requirements for accessing EPHI remotely.
- Automatic substantiation requirements when employees use a debit card with Flexible Spending Accounts.
- Medicare Part D notice requirements for group health plans: notices employers must issue to Medicare-eligible participants as well as the annual notice sent to the Centers for Medicare and Medicaid Services (CMS).
- Proposed Section 125 regulations that take effect in 2009.
- Department of Labor modified guidelines requiring employers to submit Form 5500 electronically.

Many employers were hoping updated FMLA regulations would be issued this year. The government requested com-

ments from employers and administrators, and it received 15,500 responses. However, new FMLA regulations have yet to be released. They are expected in 2008.

This year-end checklist *Advisor* briefly overviews these legislative issues for 2007 and also revisits important annual housekeeping issues.



New HSA Guidance on 2007

This year offered a host of exciting new guidance for HSAs (health savings accounts). The number of HSA-qualified high deductible health plans continues to grow at a steady pace. As HSAs become more attractive, more employers are likely to offer them.

Key HSA information released this year includes:

- **HSA contribution limit:** Released at the end of 2006, the HSA contribution limit increased for many. Before 2007 the contribution limit was the “lesser of the plan deductible or the IRS set limit.” Now the limits are simply the IRS set limits for the

coverage category elected. This provision gives employees a greater opportunity to set-aside tax-favored funds in an HSA.

- **Mid-year enrollment:** The requirement that the mid-year enrollment contribution limit be pro-rated for the number of months covered under the plan was difficult for employees. The full calendar year deductible applied, but contributions to the HSA were pro-rated. The 2007 guidelines allow mid-year enrollees (for example, new hires that meet the new hire waiting period) to set aside the full annual contribution limit. Certain requirements apply. More details on the requirements can be found in our Special Alert at http://www.mcgrawwentworth.com/Special_Alert/2007/Special_Alert_Issue_1.pdf.
- **Rollovers:** Rollovers from HRAs, Medical FSAs, or IRAs are permitted in very limited circumstances. Previously, rollovers were permitted only from other HSAs and Archer MSAs. These rollovers give employees a chance to deposit some seed money into an HSA.



However, employees can rollover these funds only once per lifetime and only if they meet certain requirements. For more information on these rollovers, please see our Special Alert at http://www.mcwent.com/Special_Alert/2007/Special_Alert_Issue_3.pdf.

- **FSA grace period:** The FSA grace period caused difficulties for individuals enrolling in a high deductible health plan and their ability to contribute to an HSA. The grace period alone could disqualify an individual from contributing to an HSA during

the first three months of the plan year. The guidance released at the end of 2006 allows employees who have a medical FSA grace period to contribute to the HSA on the first day of the plan year if they had no funds available in their FSA account on the last day of the plan year. For more information on this guidance, please see our Special Alert at http://www.mcgrawwentworth.com/Special_Alert/2007/Special_Alert_Issue_1.pdf.

- **Comparability requirements:** First, the government allowed employers to fund non-highly

compensated employees' HSAs in greater amounts than highly compensated employees' HSAs without violating the comparability requirements. In addition, the IRS spelled out the rules employers must follow if an employee fails to set up an HSA. In this case, employers were unsure how to make comparable contributions if an employee failed to establish an HSA. The IRS also set forth guidelines for how employers may accelerate their contributions to an HSA if an employee has a large claim at the beginning of the plan year. These situations have specific requirements an employer must follow. The details of these situations can be found in our Special Alert at http://www.mcgrawwentworth.com/Special_Alert/2007/Special_Alert_Issue_5.pdf.

The government will likely continue to issue HSA clarifying guidance throughout 2008. McGraw Wentworth will keep you informed of any new developments.

Final HIPAA Non-Discrimination Rules

Final HIPAA non-discrimination rules went into effect for group health plans with plan years beginning on or after July 1, 2007. These new HIPAA non-discrimination rules affect calendar year plans as of January 1, 2008.

The good news is that these final rules were similar to the proposed HIPAA rules. If your plan has already integrated the concepts of the

NOTABLE THOUGHTS

NINE-TENTHS OF WISDOM IS BEING WISE IN TIME.

**THEODORE ROOSEVELT (1858-1919)
26TH US PRESIDENT**

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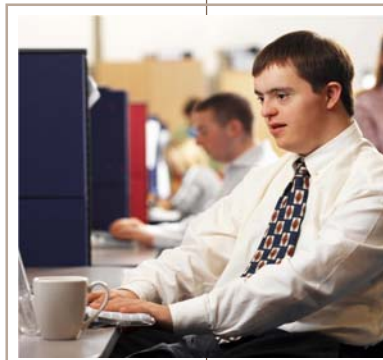
proposed rules, it probably complies with the final rules. However, the non-discrimination rules affected some very deep seated health plan practices and many plans have not made the required changes.

If you have not yet reviewed your plan to be sure it complies with the HIPAA non-discrimination requirements, that review should be an important project for 2008. Most organizations know non-discrimination requirements apply to wellness plans, but these requirements affect many other areas of the health plan as well.

HIPAA non-discrimination rules prevent organizations from discriminating in health coverage because of an individual's medical condition. These rules impact the following key areas of your health plan:

- **Eligibility:** Under the eligibility rules, carriers cannot make plan enrollment depend on adequate evidence of insurability. A carrier can ask employees to complete medical questionnaires when they enroll. However, a carrier or administrator cannot decline coverage on a specific person or a dependent because of health history or poor claim experience.
- **Benefits:** A plan can limit or exclude benefits specific to a certain disease or a certain type of treatment, but the limit must apply equally to all similarly situated individuals. These regulations set forth protocols for making plan changes, especially when a plan change affects a plan participant in the middle of a course of treatment. The regulations provide numerous examples of discriminatory plan designs.

- **Source of Injury Exclusions:** Source of injury exclusions generally exclude coverage for medical expenses that result from participation in a high risk recreational activities, such as motorcycling, horse-back riding and so on. The final regulations make very clear that the plan cannot determine eligibility for coverage based on participation in potentially high risk recreational activities. The plan can exclude coverage for certain accidental injuries. For example, a plan is able to exclude injuries related to a bungee jumping accident or a motorcycle accident. However, if a group health plan generally provides coverage for treatment of injuries, the HIPAA non-discrimination rules **require** the plan provide benefits for any injury if it results from an act of domestic violence or as a result of a medical condition (either physical or mental condition).



- **Actively at Work or Non-Confinement Clauses:** Including actively at work provisions or non-confinement clauses is generally seen as conditioning enrollment based on an individual's health status, which is not permitted by the non-discrimination rules. Employers can include an actively at work clause if the coverage effective date is not conditioned on a health status factor. Most plans do not take this approach because

it is too difficult to effectively administer.

- **Wellness Plan Incentives:** The new regulations clarify many issues that affect the strategies employers are using or considering to encourage employees and dependents to participate in wellness or disease management programs. A wellness plan is a program designed to promote health or prevent disease. The final regulations allow employers to use both benefit differences and contribution differences as an incentive to participate in a wellness plan. In some cases, these differences can be used as an incentive to meet a specific health standard. If the incentive simply encourages plan participation, both benefit and contribution differences are permitted. It gets a bit

more complicated if the organization wants to use the incentive to reward employees when they achieve a specific health goal.

The non-discrimination rules can be complicated. If

your organization is planning to launch a wellness plan, you should make sure your incentive strategy does not violate HIPAA's non-discrimination rules.

More details on the HIPAA non-discrimination rules can be found at http://www.mcwent.com/Benefit_Advisor/2007/BA_Issue_1.pdf.

Clarification on HIPAA Security Requirements

HIPAA security rules went into effect for group health plans in the last two years. Many plans are still working through their compliance requirements. However, as news reports include more and more stories about electronic data compromised while employees work remotely, CMS decided to provide additional guidance to help employers with security compliance.

The guidance covers data downloaded to portable devices, such as laptops and USB drives, and data that resides on servers accessible from remote sites. The guidance recommends security steps organizations should consider to protect their data in these circumstances. More information on this guidance can be found in our Special Alert at http://www.mcwent.com/Special_Alert/2007/Special_Alert_Issue_2.pdf.

Automatic Substantiation with Debit Cards

In 2006, the IRS released Revenue Ruling 2006-69 on using debit cards to pay claims from medical flexible spending account funds. The IRS limited debit card use to merchants with a health care related merchant code. Retailers such as grocery stores and other primary businesses that are not health care related would need to have an Inventory Information Approval System or IIAS. This system allows the debit card vendor to confirm the card is being used for an eligible expense.

It seems simple, but many merchants do not use the IIAS. Originally, the effective date for meeting this requirement was January 1, 2007. Because of numerous complaints that vendors needed more time, the IRS

decided to extend the deadline. However, the new effective date is January 1, 2008, and that day is drawing near.

If your medical flexible spending account participants use a debit card, it may be wise to contact your FSA administrator to discuss how to notify your employees of these requirements. Technically as of January 1, 2008, your plan should not allow employees to use the debit card at a non-health care merchant, unless the merchant uses the IIAS.

Medicare Part D Notice Requirements

CMS issued separate guidance this year on Medicare Part D notice requirements. Medicare Part D is the voluntary prescription drug program that went into effect January 1, 2006. Since the Part D coverage includes late enrollment penalties if an individual who is Medicare eligible fails to maintain creditable drug coverage, the status of employer provided drug coverage is important.

CMS has two notice requirements: one must be sent annually to Medicare eligible individuals and another must be filed annually with CMS. New guidance was issued on both notice types this year.

The new guidance slightly updated the wording of the model notices sent to Medicare eligible participants. The new guidance also considerably relaxed the requirements for delivering the notice electronically. Initially if a health plan wanted to deliver the notice electronically, it

needed the plan participant's consent. With the new guidance, if employees have daily access to the employer's electronic information system as part of their jobs, employers may deliver the notice electronically. The employer must tell the employee to provide the notice to any Medicare eligible dependent the health plan covers. For more information of the latest guidance, please read our Special Alert at http://www.mcgraw_wentworth.com/Special_Alert/2007/Special_Alert_Issue_4.pdf.

Late this year the government issued additional guidelines on filing an annual creditable coverage status notice with CMS. Although much of the detail remains the same, the new guidance did provide more information on what CMS expects from

group health plans. The toughest part for employers is remembering to logon and complete the electronic form within 60 days of the beginning of the plan year. For

more details on this guidance, please see our Special Alert at http://www.mcgraw_wentworth.com/Special_Alert/2007/Special_Alert_Issue_8.pdf.

New Proposed Section 125 Regulations

The IRS also released proposed Section 125 regulations this summer and has requested comments on them. The proposed regulations affect plan years beginning on or af-



ter January 1, 2009, and incorporate much of the Section 125 guidance issued in the last decade. If your plan has kept up-to-date with guidance in the past, this latest round of regulations should not cause a problem.

Some of the areas of interest include:

- The new rules require a plan to satisfy all the requirements of Section 125 or else the plan is not considered a qualified Section 125 plan. If the plan is not qualified, all participants lose the tax-favored basis. The rules require the plan to issue a written document.
- The new guidance once again states the plan year must be 12 consecutive months and short plans years are allowed only for valid business reasons.
- The new guidance shows examples of how to calculate imputed income on a Section 125 pre-tax contributions for voluntary life coverage.
- The new regulations increase flexibility for participants contributing to Health Savings Accounts under a Section 125 plan. HSA contributions can be changed more frequently than once a year. In fact, contributions can change for each pay period if the changes are made prospectively.



Medicare Information

Medicare Part A Deductible	\$1,024.00
Hospital Per Day Copay	
60 to 90 day stays	\$256.00
90+ day stays	\$512.00
Skilled Nursing Facility Per Day Copay (after 20 days)	\$128.00
Medicare Part B Monthly Premiums	\$96.50
Medicare Part B Annual Deductible	\$135.00

- The new guidelines incorporate all the rules for paying claims with debit cards as well as rules for auto substantiation.

These are just a handful of the issues covered in the proposed Section 125 regulations. For more details, please read our Benefit Advisor at http://www.mcwent.com/Benefit_Advisor/2007/BA_Issue_10.pdf.

Electronic 5500 Filing

The government changed the effective date for mandatory Form 5500 electronic filing. Initially the rules affected plans beginning on or after January 1, 2008. Under the new guidelines the effective date for mandatory electronic filing affects plans beginning on or after January 1, 2009. The Form 5500 must be filed within 210 days following the close of the plan year. For calendar year plans, this means the Form 5500 filed in July of 2010 will now be the first one that must be filed electronically.

The government hopes mandatory electronic filing will save money and time. The goal is to allow plans two options when they submit Form 5500 electronically:

1. Employers may file electronically using a system called EFAST. Employers can choose from a number of EFAST software programs available. The DOL currently has a request for proposal out to update the EFAST software. The software may change, but employers will still have the option to use an approved software vendor to file the Form 5500 electronically.
2. Employers may submit Form 5500 information electronically over the Internet. The government is working on building the technology and security systems to make this Internet option available.

It appears the government is still working through the technical issues, which is likely why the effective date has been delayed a year. McGraw Wentworth will keep you informed as the Department of Labor releases additional information.

Annual Reminders and Updates

- 2008 Medicare Information**
 The Department of Health and Human Services released the Medicare information for 2008 (see table at the top of page 5).

Last year was the first year that income-based Part B premiums were introduced. Individuals with incomes of more than \$82,000 or joint return filers with incomes of more than \$164,000 will be charged higher premiums for Part B coverage. For 2008, the increased premiums will be charged as noted in the table at the bottom of the page.

Launched in January 1, 2006, Medicare Part D is Medicare outpatient prescription drug coverage offered through approved private insurance carriers. The coverage has cost-sharing features indexed every year. The standard benefit plan provisions for 2008 are noted in the table at the top of the page.

Medicare Part D also affected employers sponsoring retiree drug plans. Employers could choose to work with Medicare Part D in a number of ways. One option was to apply for a

	2008
Annual Deductible (amount the beneficiary pays before benefits are payable)	\$275
Initial Coverage Limit (once the beneficiary meets the deductible, the plan pays 75% and the beneficiary pays 25% until the total prescription expense - paid by plan and beneficiary - reaches the initial coverage limit)	\$2,510
True Out-of-Pocket Maximum (once the beneficiary has paid the true out-of-pocket cost, Medicare catastrophic coverage will pay the majority of prescription drug cost). The standard plan pays no part of expenses after initial coverage limit is met until the True Out-of-Pocket Maximum is reached.	\$4,050
Total Covered Part D Expenses before Catastrophic Coverage (if the beneficiary has no coverage other than the Medicare Part D plan)	\$5,726.25
Catastrophic Coverage (Medicare pays most of the prescription drug expense once the catastrophic coverage level is reached.) The Medicare beneficiary pays the greater of 5% of drug cost or a \$2.25 generic or \$5.60 brand name copay.	

government-paid subsidy based on a percentage of claims paid. The subsidy equals roughly 28% of prescription claims for Medicare Part D covered medications that fall between the cost threshold and cost limit.

The cost threshold and cost limit are also indexed and the 2008 amounts are as follows:

Cost Threshold	\$275
Cost Limit	\$5,600

- Group Term Life Insurance: Section 79**

Each year, employers need to review their employer-provided life coverage to determine whether their employees' group term life coverage is taxable.

Employers have to impute income for the value of the life insurance plan in only a few instances:

- If the employer-paid life insurance exceeds \$50,000.
- If the life plan favors key employees.
- If the employee-paid optional life plan rate tables straddle Table 1 rates.
- If the employer allows voluntary term life coverage to be paid with pre-tax dollars.

Individual Return	Joint Return	2008 Part B Monthly Premium
\$82,001-\$102,000	\$164,001-\$204,000	\$122.20
\$102,001-\$153,000	\$204,001-\$306,000	\$160.90
\$153,001-\$205,000	\$306,001-\$410,000	\$199.70
>\$205,000	>\$410,000	\$238.40

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The most recent *Benefit Advisor*, available on our website, explains when and how to calculate imputed income.

W-2 Forms for STD Benefits

At year end, organizations need to account for any disability benefits or earnings they paid to disabled employees during the year. Although in many cases, disability carriers pay the benefits, employers need to make sure these benefits are accounted for on the employee's W-2. Any employees who received short-term disability benefits under your STD (short-term disability) plan in 2007 need W-2s.

The income is generally reported in one of two ways:

- Disability carriers or third party administrators may issue W-2s directly to

participants who received benefits during the year.

- Carriers or administrators may send you a quarterly or annual report with the information you must include on each employee's W-2.

Your STD insurer or STD administrator may issue W-2s for your employees. If the insurer issues the W-2 separately, it is wise to let employees who had claims in 2007



know that they will receive a separate W-2 from the disability vendor. More often disability vendors inform employers of the amount

paid in disability benefits and then employers add the benefit income to the employee's W-2.

If your organization self-funds STD benefits, you will need to include those benefits in the employee's 2007 W-2. If you use a payroll service to issue W-2s, your payroll vendor must

include the additional compensation on the employee's W-2.

- **2008 Indexed HSA Limits:** Important legislation passed at the end of 2006 increased HSA contribution limits. Previously, the contribution limit was linked to the deductible amount of the high deductible health plan. Beginning in 2007, the IRS set forth the HSA contribution limits as outlined in the table below.
- **2008 Indexed Plan Limits** The Table on page 8 summarizes the 2007 and 2008 indexed plan limits

Conclusion

Year-end is always a busy time both professionally and personally. It makes sense to review this checklist to make sure your organization accounts for new legislation as well as run-of-the-mill housekeeping issues. If your organization has missed a key notice or legislative requirement, make that issue a priority in 2008.

Good luck in handling the year-end compliance issues that affect your organization's benefit plans. The McGraw Wentworth staff wishes you and your family a happy, healthy and prosperous 2008! **MW**

Health Saving Account Limits	2006	2007	2008
HDHP Minimum Deductible			
Self Only Coverage	\$1,050	\$1,100	\$1,100
Family Coverage	\$2,100	\$2,200	\$2,200
HDHP Maximum Out-of-Pocket			
Self Only Coverage	\$5,250	\$5,500	\$5,600
Family Coverage	\$10,500	\$11,000	\$11,200
HSA Statutory Contribution Maximum			
Self Only Coverage	\$2,700	\$2,850	\$2,900
Family Coverage	\$5,450	\$5,650	\$5,800
Catch-Up Contribution (age 55 and older)	\$700	\$800	\$900

Indexed Plan Limits

Plan Limits	2007	2008
Section 401(k) or SAR-SEP	\$15,500	\$15,500
Section 402(g) maximum pre-tax contribution by employees for elective deferrals	\$15,500	\$15,500
Age 50+ Catch-Up Deferral Limit	\$5,000	\$5,000
Section 403(b) Plan	\$15,500	\$15,500
Section 408(p)(2)(A) SIMPLE Plan Contributions	\$10,500	\$10,500
Section 457(b)(2) Limit	\$15,500	\$15,500
Key Employee Determination - Officers' Earnings Threshold	\$145,000	\$150,000
Section 415 Limit for: Defined Contribution Plans (calendar year) Defined Benefit Plans	\$45,000 \$180,000	\$46,000 \$185,000
Highly Compensated Employees Section 414(g)	\$100,000	\$105,000
Includible Compensation - Section 401(a)(17)	\$225,000	\$230,000
FICA Taxable Wage Base: Social Security (Tax Rates 6.2%) Medicare (Tax Rate 1.45%)	\$97,500 No limit	\$102,000 No limit

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