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### HEALTH BENEFITS

This  
Just  
In...



**A new IRS rule makes it easier to use debit cards on flexible spending accounts (FSAs).** Debit

cards make administration of FSAs easier for employers. However, in the past, IRS rules required employers to send 1099s to health care providers who received \$600 or more from employees who made payments with debit cards attached to their FSA and health reimbursement accounts. Congress recently overruled the IRS, saying that employers do not have to send 1099s to these providers. The new rules apply retroactively to Jan. 1, 2003.

**A February Supreme Court decision will let employers that change retirement benefits breathe a bit easier.** In an interesting twist on age discrimination claims, a group of employees in their 40s sued their employer under the Age Discrimination in Employment Act (ADEA), claiming the company had discriminated against them by offering better retirement benefits to those over age 50. The ADEA prohibits employment discrimination against those age 40 and older. The Supreme Court ruled that the ADEA does not address such "reverse discrimination" situations. The decision is significant, as many employers are looking for ways to control the cost of offering retirement benefits. *Land Systems v. Cline*.

## HSA Update

**T**he Medicare Prescription Drug, Improvement, and Modernization Act of 2003 permitted eligible individuals to establish health savings accounts, or HSAs, after December 31, 2003. To be eligible, an individual must have a high-deductible health plan (HDHP) and no other health insurance, except for certain plans providing limited coverage.

As with many complex legislative bills, the Medicare Act left some questions unanswered before it became law. The IRS and Department of Labor recently responded by issuing guidelines for plan administrators and insurers on some of these topics:

**What exactly is "preventive care" under a HDHP?** To be eligible for an HSA, an individual must have health coverage solely through a high-deductible health policy, or HDHP. The IRS defines a high-deductible health policy as one with an annual deductible of at least \$1,000 and annual out-of-pocket expenses not exceeding \$5,000 for an individual. For family coverage, an HDHP has an annual deductible of at least \$2,000 and annual out-of-pocket expenses of not more than \$10,000. Preventive care is not included in this deductible. However, the Medicare Act did not define what exactly constitutes "preventive care." To provide guidance to plan administrators, the IRS has issued Notice 2004-23, which details what services constitute "preventive care."

**Can individuals who have a stand-alone, copayment-only prescription drug plan remain eligible for an HSA?** The Medicare law prohibits individuals with "other health insurance" besides an HDHP from participating in an HSA. Unfortunately for employers that already offer stand-alone prescription drug coverage, the IRS says this type of prescription drug coverage counts as "other health insurance." Any prescription drug benefits must have the same deductibles as an HDHP plan to qualify participants for an HSA.

The law as written as written did not specify whether this type of stand-alone prescription drug plan would count as "other health insurance." Because some insurers and benefits administrators interpreted the law differently, the IRS will allow an otherwise eligible individual with this type of prescription coverage to remain



**EMPLOYEE  
BENEFITS  
REPORT**

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# If It Sounds Too Good to Be True...

...it probably is, especially when it comes to health insurance. As health insurance costs skyrocket, the number of fraudulent plans increases. A U.S. General Accounting Office (GAO) report released in March revealed some scary statistics:

- ✘ At least 144 unauthorized entities sold health insurance between 2000 and 2002.
- ✘ At least five such unauthorized sellers operated in every state, although most operated in the South.
- ✘ At least 15,000 employers fell victim to unauthorized or bogus health insurance plans.
- ✘ Unauthorized or bogus health insurance policies affected at least 200,000 policyholders during this time.
- ✘ Unpaid claims totaled at least \$252 million.

These health insurance scams can leave innocent people with unpaid medical bills when they're sick and most vulnerable.

## Spotting a fraudulent plan

How can you spot a fraudulent plan? Some warning signs:

- ✘ Premiums that are 25 percent or more lower than any other competitor's.
- ✘ Promises to cover anyone, regardless of pre-existing conditions (for individual policies) or with no waiting period for pre-existing condition coverage (for group policies).
- ✘ Plans claiming to be ERISA plans, which are exempt from state regulation. (ERISA, the Employee Retirement Income Security Act, as a federal law, supercedes state insurance laws.) Legitimate ERISA plans include union plans and certain employer-provided plans; however, unions or employers establish these plans for their own members or employees—they are not open to others.



- ✘ Offers to join a business or trade association not affiliated with your industry just to obtain coverage. While some trade associations do offer legitimate group insurance programs, some so-called trade groups exist merely to provide benefit programs. Before buying any policy, verify that the insurer is authorized to do business in the state.

- ✘ Plans that pay small claims at the beginning, then suddenly stop paying claims.

- ✘ Plans that demand payment for more than a month up front.

## Protecting your firm

Your state insurance department can tell you whether a health insurer is authorized to do business in your state. Beware sound-alike names—many fraudulent plans use names that sound similar to those of legitimate companies. Others may use names that sound like a government agency, particularly those that sell to elderly consumers.

## Medical discount cards – savings or scam?

Medical discount card programs have existed for decades, but sales have been increasing lately. Programs promise members discounts on medical (and sometimes dental) appointments and emergency care of up to 60 percent. Anyone can become a “member,”

regardless of age or pre-existing condition, so they appeal to the uninsured or to small employers that can't afford group insurance for their employees.

But are they worth the price? An article in the *Wall Street Journal* said most cards cost between \$40 and \$100 per month.

They may also charge administrative fees that might not be clearly disclosed at sale time. New York state Attorney General Eliot Spitzer recently brought suit against two discount health card marketers for failure to disclose the costs and benefits of their cards. Among other things, the companies charged members pharmacy dispensing and banking fees, in addition to the monthly membership fee.

To determine if a medical discount card is worth the invest-

**President Bush has endorsed association health plans as a way to reduce the cost of insurance coverage for small employers.** The Bush proposal would allow small employers to create associations to buy coverage and exempt these association plans from state regulation. This may lower costs in the short run by allowing association plans to provide “bare-bones” coverage free of state-mandated benefits. However, critics caution that changing the existing system of state regulation would make consumers more vulnerable to fraud.

eligible for an HSA until January 1, 2006.

**Do other types of insurance disqualify individuals from participating in HSAs?** The Medicare Act specifically permitted individuals with coverage for accidents, disability, dental care, vision care or long-term care, a specified disease or illness or “per diem” hospitalization coverage to participate in HSAs. Individuals with Archer Medical Savings Accounts (MSAs) can convert them to HSAs, which are intended to replace MSAs.

**Can HSAs reimburse medical expenses retroactively?** The Medicare Act allows HSAs to reimburse or pay medical expenses on a tax-free basis if the expense was incurred after the HSA was established. However, the IRS said that, “[B]ecause of the short period between the enactment of HSAs and the effective date, many taxpayers who otherwise would be eligible to establish and contribute to HSAs...have been unable to do so because they cannot locate trustees or custodians who are willing and able to open HSAs at this time.” Therefore, for calendar year 2004, the IRS will permit an HSA established on or before April 15, 2005 to pay or reimburse on a tax-free basis an otherwise qualified medical expense as long as it was incurred on or after January 1, 2004 or the first day of the first month that the individual become eligible for an HSA.

**Does ERISA apply to HSAs?** This is an important issue for employers, because ERISA, the Employee Retirement Income Security Act, subjects sponsors of “employee welfare plans” to reporting, fiduciary responsibility and other requirements. The Department of Labor has issued a Field Assistance Bulletin that says generally, an HSA is not an “employee welfare plan” subject to ERISA, even though the employer makes contributions, as long as:

- 1 Employee participation is completely voluntary,
- 2 The employer does not limit the ability of eligible individuals to move their funds to another HSA beyond restrictions imposed by the Code,
- 3 The employer does not make or influence the investment decisions with respect to funds contributed to an HSA,
- 4 The employer does not make representations that HSAs are an employee welfare benefit plan established or maintained by the employer.

Employer involvement in HSA administration, including selecting a plan trustee or opening HSA accounts for employees, may subject the plan to ERISA requirements.

Although ERISA does not apply to many HSAs, it does apply to an underlying employer-sponsored high-deductible health plan (HDHP), unless it is sponsored by a government agency or church.

**Do HIPAA privacy protections apply to HSAs?** HIPAA does not apply to group health plans with fewer than 50 participants. However, other plans may be considered “covered entities” for purposes of HIPAA. If the employer opens or

maintains the plan, HIPAA privacy protections might apply to your HSA. To protect your employees’ privacy and avoid liability for privacy violations, you should use the same sort of “firewalls” to protect HSA information as you do for other health insurance information. This means keeping HSA account information separate from other personnel information and ensuring that people with responsibility for making hiring or promotion decisions do not have access to HSA account information.

## The future of HSAs

Many insurers have already jumped on the HSA bandwagon and are offering high-deductible health plans that qualify participants for HSAs. However, employers or individuals looking to set up HSA accounts might have a harder time finding a trustee or custodian willing or able to set up an HSA account.

According to the *HSA Insider*, a mere 14 banks were opening HSAs as of April 29. (See [www.hsainsider.com/trustees.asp](http://www.hsainsider.com/trustees.asp) for a list.) Demand from employers is likely to drive that number up, though—Mercer Human Resource Consulting found that 73 percent of employers surveyed said they were either “very likely” or “somewhat likely” to offer a high-deductible health plan along with an HSA by 2006.

In addition to availability, some other questions remain. Families with HSA-linked HDHPs could end up paying more out of pocket than they would under a traditional plan with similar deductibles. The legislation that created HSAs requires underlying HDHPs to have an annual deductible of at least \$1,000 for individuals and at least \$2,000 for family coverage. More traditional health plans also have individual deductibles “embedded” into the family plan. However, once the individual meets his/her deductible, the traditional plan covers eligible expenses for that individual, even though the family has not met the family deductible.

As an example, let’s say an individual with family coverage incurs \$1,800 in covered expenses at the very beginning of the calendar year. Under a traditional plan with a family deductible of \$2,000 and individual deductibles of \$1,000, he would pay the \$1,000 individual deductible; the plan would cover the remaining \$800. Under an HDHP with the same deductibles, he would have to pay the entire amount unless the family already had other claims that could apply to the family deductible. Employers that switch to HDHPs will have to explain this difference to employees with family coverage. However, the advantages of HSAs, including portability and tax-free growth, can help offset any perceived disadvantages. Good communication and education can increase employee acceptance of these plans.

A recent poll by Destiny Health Plans found that most consumers are interested in HSAs. Between 61 and 78 percent of respondents under the age of 65 said they were interested in HSAs, according to the poll. This indicates an opportunity for employers looking to provide more cost-effective health care for their employees.

For more information on HSAs and selecting HSA-qualified HDHPs, please call us. □

**Many insurers have already jumped on the HSA bandwagon... However, employers or individuals looking to set up HSA accounts might have a harder time...**

# Privacy Regs Now Apply to Smallest Health Plans

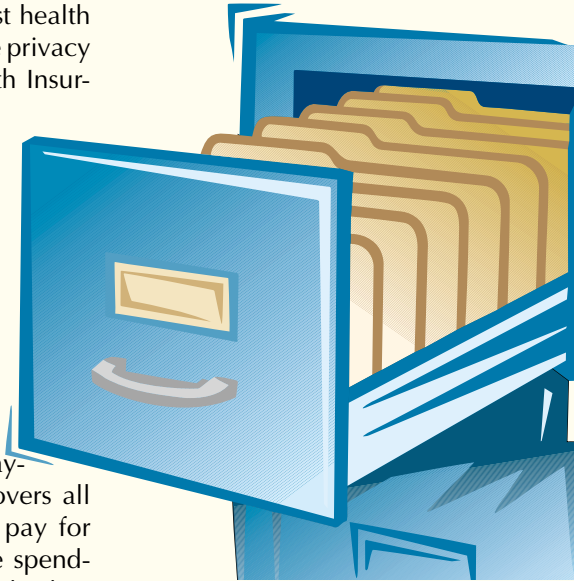
**B**y April 14, even the smallest health plans had to comply with the privacy regulations of HIPAA, the Health Insurance Portability and Accountability Act. Enacted in 1996, the law has become effective in stages. On April 14, plans with less than \$5 million in annual premiums and self-insured plans with less than \$5 million in annual claims fell under the law.

The law prevents the disclosure of individually identifiable health information except where needed for treatment, payment and plan operations. It covers all types of plans that provide or pay for medical care, including flexible spending accounts (FSAs). However, the law exempts health plans with fewer than 50 participants and administered by the sponsor.

## Employers have responsibilities, too

Although responsibility for compliance rests primarily with insurers and self-insured entities, the law does require employers to notify all employees and their dependents of their privacy rights under HIPAA. Your insurer (or third-party administrator, for self-insured plans) can probably provide appropriate forms. Employers will also want to verify that insurers and other business associates that may have access to protected health information (such as a third-party administrator or COBRA compliance administrator) comply with HIPAA regulations. To protect your organization, verify that your contracts with business associates require them to safeguard protected health information (PHI) to prevent its unauthorized use or disclosure.

The law also requires employees to have access to their PHI. They may review it, amend it and receive an accounting of its use and disclosure. Therefore, employers need policies and procedures to allow employees to gain access to their



PHI and receive an accounting of its use and disclosure. Employers must store this PHI separately from other employee records and limit its access to those with a need to know for purposes of treatment, payment of benefits or plan operations.

For more information on HIPAA compliance, visit the Department of Labor's Compliance Assistance section at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). □



**Trying to track down former employees or dependents with information on unclaimed pension benefits?**

The IRS offers a Letter-Forwarding Program that protects the individual's privacy by forwarding the letter for you. All you need to provide is the letter and the individual's Social Security number. The IRS offers the program for humanitarian purposes only, which includes financial entitlement. You cannot use the program for service of process or to locate a party to pending litigation. The IRS's Web site has more information; look up Revenue Procedure 94-22.



**A pension relief bill recently became law.** HR 3108 changed the way companies value their pension liabilities, retroactive to January 1.

Before HR 3108's passage, plan sponsors valued their pension liabilities using an interest rate of 105 percent of the four-year weighted average of the yield on a 30-year Treasury bond. This relatively low rate of interest meant companies had to set aside more funds to meet future pension obligations. HR 3108 allows pension plans to use higher corporate bond rates, which means companies have to put aside less money to meet their pension obligations. The change will have no effect on payouts retirees actually receive under defined benefit pension plans.

## TRUE – continued from Page 2

ment, ask the following questions:

- ✓ Do buyers pay the company anything besides the monthly membership fee? If yes, what are the charges for and how much are they?
- ✓ What providers (physicians, pharmacies, hospitals, emergency rooms) in this area accept the cards? Are they under contract to accept the cards, or can they change their policy without notice?
- ✓ Are discounts through this pro-

gram the lowest available? Often, medical providers will discount services for patients who lack insurance. These discounts may equal any discounts available through card programs.

Medical discount cards cannot substitute for a group or individual health insurance policy. Some programs may provide valuable discounts, but even the best of these programs cannot provide the benefits of an insurance policy. For more information on obtaining quality group coverage, please call us. □



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