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This  
Just  
In...

## BENEFIT ADMINISTRATION

# Give Your Health Benefit Program a Charge



### Medicare expansion bill passes.

As this newsletter went to press, the Senate and House approved bills that would provide prescription drug benefits to seniors in traditional Medicare plans. It would allow seniors in traditional Medicare plans to buy standalone prescription drug policies from private insurers to provide these benefits. Seniors in Medicare HMOs and PPOs would continue to get prescription benefits through their plans.

The House version was combined with a bill that would allow individuals to have tax-exempt personal savings accounts to pay qualified medical expenses. Some legislators criticized these proposed plans, saying they would give employers incentive to cut back on health benefits and create tax shelters for the rich and healthy. The House bill would also allow for direct competition between private health insurers and traditional Medicare plans in the future. A House and Senate conference committee must reconcile the two bills before the program becomes law.

Some observers warn payroll taxes may have to increase to pay for the program, especially if savings projected

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Some third-party benefit administrators make debit cards available with flexible spending accounts. Although the cards make it easier for plan participants to use their benefits, many employers have hesitated to sign up for these programs due to concerns over Internal Revenue Service regulations. A recent IRS ruling formally approving the use of debit or credit cards for flexible spending and health reimbursement accounts (FSAs and HRAs) should clear the way for wider acceptance of these programs.



The IRS ruling, 2003-43, takes effect at the end of the year. It clarifies that amounts charged to a debit or credit card linked to employees' FSA or HRA qualify for exclusion from gross income if: 1) all participants receive a card upon enrollment, 2) participants certify each year that they will use the card only for eligible medical expenses and that they will not receive reimbursement from any other source, 3) cards have a similar certification printed on them and 4) participants keep documentation for these expenses. Further, transactions must be 1) pre-approved, such as office visit copayments or the cost of refilling a previously ordered prescription or 2) substantiated as qualified medical expenses at time of transaction. Otherwise, the card must pay expenses conditionally and employees must submit receipts to substantiate expenses and must repay any unqualified expenses.



**EMPLOYEE  
BENEFITS  
REPORT**

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# Using Carve-Outs to Cut Costs

As health insurance prices continue to increase, benefit and human resource managers are looking for different ways to cut costs. Some are turning to carve-outs, a risk financing technique in which a group “carves out” coverage for specific procedures or expenses from a broader insurance program and covers them separately—either with a separate policy or through self-insurance.

What coverages typically come under the carve-out knife?

## Prescription drugs

Prescription drug costs accounted for only 10 percent of group medical costs in 2002, but inflation of prescription drug costs far outpaces inflation in other medical costs. Direct-to-consumer advertising, new (and costly) drugs and so-called “lifestyle” drugs such as Viagra have helped fuel this trend. Some employers have responded by carving out prescription drug benefits from their group health plan. Instead of buying prescription coverage through an insurer, these employers self-insure prescription drug benefits. Employers can structure their self-insured prescription drug program to control costs by:

- ✱ Setting an annual maximum benefit.
- ✱ Setting employee copayment percentages.
- ✱ Eliminating the insurer’s profit margin

Make sure any MHSA provider you contract with complies with federal and state mental health parity laws. The Mental Health Parity Act of 1996, renewed until December 31, 2003, prohibits group health plans sponsored by employers with more than 50 employees from putting higher annual and lifetime dollar limits on mental health benefits than on medical or surgical benefits. However, the law does not require exact parity; for example, employers can limit the number of covered inpatient days or office visits, or require higher copayments or deductibles for mental health treatment. The Paul Wellstone Mental Health Parity Act, which would eliminate loopholes in the 1996 act, seems unlikely to pass during this legislative session, despite bipartisan support. Thirty-three states currently have their own mental health parity laws.

## Mental health/ substance abuse benefits

During the 1990s, employers began carving out coverage for mental health and substance abuse (MHSA) treatment and contracting with specialty mental health and substance abuse vendors to provide these benefits. Under these MHSA plans, family doctors and other primary care physicians refer patients with mental health or substance abuse programs to one of the vendor’s providers. Such programs can help cut costs by steering group members with mental health and substance abuse problems away from costly traditional inpatient facilities to less expensive outpatient care or partial hospitalization services and toward specialized facilities.

## Transplants

Even health plans use carve-outs to control their costs. Some HMOs (health maintenance organizations) carve out coverage for costly or highly specialized pro-

cedures, such as organ transplants, and refer these cases to a specialized transplant hospital or physician group. Self-insured employers also often carve out transplant risks—a strategy that makes sense when you consider that a single heart transplant surgery can cost as much as \$500,000 when drugs and follow-up care are included.

Carving out coverage for transplants can help self-insured employers better predict their health care costs. Furthermore, carve-out programs can provide case management and other services that help improve outcomes and reduce costs of individual cases. For more information on carve-outs and other cost-control strategies, please call us. □



“...inflation of prescription drug cost far outpaces inflation in other medical costs.”

Employees can use the debit cards anywhere that accepts Visa or MasterCard to pay for qualified medical expenses as they occur. No need to complete paperwork and wait for reimbursement—the funds come immediately out of the employee’s account at point of sale. The IRS ruling does not require employers to substantiate debit card expenses if the dollar amount of a transaction equals the dollar amount of a plan’s copayment for the service. This can help employers reduce the paperwork associated with administering FSAs and HSAs.

### Benefits of debit and credit cards

Debit or credit cards linked to FSAs offer advantages for employers and employees. They include:

- ✓ Increased participation. When cards are offered, “...FSA participation goes up anywhere from 10% to 70%.” Bob Patricelli, CEO of Avon, Conn.-based Evolution Health, told *Employee Benefit News* magazine.
- ✓ Tax savings. Encouraging more employees to participate in FSAs may bring payroll tax savings to employers. Employee contributions to FSAs reduce gross income, lowering the amounts on

which employers must pay payroll taxes.

✓ Lower claims-processing costs. Some administrators say cards can save 30 percent on claims-processing costs. This may translate into lower benefit administration fees for their employer clients.

✓ Cards may help with discrimination-testing problems. Because qualified benefit programs must not favor highly compensated employees, plans with a high proportion of highly paid personnel (such as a law firm or medical group) may run into discrimination problems if lower-paid employees do not participate. Cards make it easier for people with lower incomes to participate in FSAs and other savings plans, because they do not have to wait for reimbursement.

HSAs work differently than FSAs (employers contribute to HSAs, unlike FSAs, which use employee pre-tax dollars), so offering a debit card with these plans will have no effect on an employer’s payroll taxes or benefit discrimination-testing requirements. However, employers who tie their HSA to a debit or credit card will be offering their employees a convenient benefit and will probably lower their claims-processing costs.

For more information on FSAs or HSAs, please call our office. □

from other Medicare reforms fail to materialize. Other possible impacts include higher prescription drug prices, as pharmacies and drug plans forced to cut costs for Medicare recipients pass costs on to other insureds.



#### First court ruling issued on COBRA’s new asset sale rules.

In the first case addressing COBRA’s final rules on business acquisitions, a federal district court in Washington, D.C. held that a company’s buyer was a successor employer for COBRA purposes; therefore, it was obligated to assume the seller’s obligation to provide a former employee with COBRA coverage. The court then granted an injunction barring the buyer from denying COBRA coverage. The case is *Risteen v. Youth For Understanding, Inc.*, 245 F.Supp.2d 1 (D.D.C., Sept. 12, 2002).

Generally, the IRS final COBRA regulations require a successor employer resulting from a business reorganization to make COBRA coverage available to “affected qualified beneficiaries.” The regulations generally apply if the buying group continues the business operations “without interruption or substantial change,” and “continues to maintain a group health plan.”



#### Older applicants may have a hard time getting LTC coverage. A report by *Long-Term Care*

*Insurance Sales Strategies* magazine said that long-term care insurers decline up to 40 percent of applicants for health reasons. Buying coverage when younger and presumably healthier can help avoid this problem. In addition, premiums are lower for younger insureds—although you will likely pay them over a longer period of time.



#### The cost of retiree health benefits increased an average of 15 percent in 2002. Cost

increases for active workers’ health care averaged just under 14 percent. More companies are setting up medical savings accounts to help employees save money, which they can use to buy health insurance after they retire. □

## DEDUCTIBLE MEDICAL CARE EXPENSES

The IRS defines deductible medical care expenses as those necessary “for the diagnosis, cure, mitigation, treatment, or prevention of disease, or treatment affecting any structure or function of the body. The cost of drugs is deductible only for drugs that require a prescription by a physician, except for insulin.”

More specifically, this includes payments for:

- \* The services of doctors, dentists, surgeons, chiropractors, psychiatrists, psychologists, Christian Science practitioners.
- \* Hospital services, qualified long-term care services, nursing services, and laboratory fees, acupuncture treatments or inpatient treatment at a center for alcohol or drug addiction, smoking-cessation programs, drugs prescribed to alleviate nicotine withdrawal.
- \* Transportation expenses incurred primarily for medical care.
- \* False teeth, prescription eyeglasses or contact lenses, hearing aids, crutches, wheelchairs, and guide dogs for the blind or deaf.
- \* Premiums paid for accident and health or qualified long-term care insurance (subject to limitations). Premiums paid toward an employer-sponsored health plan are not deductible. □

# 401(k)s and Fiduciary Liability

Companies that sponsor 401(k)s are still feeling the effects of Enron and other large-scale corporate accounting scandals. As of late last year, lawyers had filed more than 100 Employee Retirement Income Security Act (ERISA) cases against companies, alleging they breached their fiduciary duty by failing to adequately monitor their 401(k) plans.

## Benefit sponsors as fiduciaries

This type of case is particularly worrisome to benefit sponsors, because the standard of proof for plaintiffs in a fiduciary liability suit is lower than in most liability claims—plaintiffs do not have to prove negligence or intent to harm; they simply have to prove the fiduciaries didn't act in the best interest of plan participants.

ERISA, the federal law that governs benefit plans, imposes a "fiduciary duty" on the officials of any company that sponsors a benefit plan. That is, they must "act for someone else's benefit, while subordinating...[their] personal interests to that of the other person. It is the highest standard of duty implied by law (e.g., trustee, guardian.)" (*Black's Law Dictionary*) ERISA includes anyone who has discretionary authority over a plan or its assets in its definition of fiduciary. This may include corporate officers, board members, investment committee members and plan trustees. Fiduciaries who fail to act with the participants' best interests in mind may be personally liable for any losses plan participants experience as a result.

A declining stock market increases the risk of fiduciary liability claims. When the market was increasing and employees saw the values of their 401(k) investments skyrocket, they were unlikely to

complain, no matter how weak the fundamentals behind those investments. But declining investments don't necessarily lead to fiduciary liability claims—you simply must manage your company's 401(k) prudently. Here are some suggestions:

1. Create a written investment policy that defines who is responsible for the plan administration and oversight and their duties. It should include guidelines for selecting investment options and service providers, procedures for monitoring their performance, and an outline of how investment expenses will be controlled and accounted for.
2. Provide a diverse selection of investment options. Many 401(k) participants have poorly diversified portfolios, leaving them at risk when the value of company stock or a particular sector of the stock market tumbles. A recent study by consulting firm Hewitt Associates Inc. found that companies have increased the investment options offered under their 401(k)s.
3. Consider providing investment advice to employees. The so-called SunAmerica letter, issued by the U.S. Department of Labor in December 2001, said that employers could provide investment advice through independent third parties. The Department issued the letter in response to SunAmerica's request to provide this type of service. Before the letter was issued, employers were reluctant to provide their employees with investment advice, for fear of being sued if employees lost money on their investments. According to an article in *Newsday*, slightly more than 35 percent of employers provided investment advice in 2000. By 2001, that had increased to 41.4 percent.



4. Give plan participants greater freedom to sell company stock in their 401(k)s. Enron provided a painful lesson on this topic—Enron employees bound by rules that prohibited them from selling company stock matches in their 401(k)s before the age of 50 watched helplessly as the value of their 401(k)s plummeted as Enron stock declined.

5. Consider purchasing fiduciary liability insurance, which specifically covers people and organizations who act as fiduciaries for an ERISA plan.

In May, the House of Representatives passed HR 1000, which addresses many of these issues. It would require 401(k) plans to allow participants and beneficiaries to divest company stock obtained from employer contributions and reinvest in other options within three years. It would also encourage diversification by requiring plans to offer at least three investment options other than employer securities. It would also require plan sponsors to provide quarterly benefit statements and quarterly opportunities to choose among investment options.

For information on 401(k)s, please call us. □



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