Employee Benefits Report

TEAGUE
FINANCIAL SERVICES

4700 Spring Street, Fourth Floor • La Mesa, CA 91941
(619) 668-5200 •(619) 469-9203 fax • www.teaguefs.com • License #0754779

Administration April 2010 Volume 8 • Number 4

Meet Your ERISA Bonding Requirements and Save Money

ERISA requires every person who handles funds for an employee benefit plan to be bonded. Read on to find out what kind of bond you need, for how much, and how to save money on it.

The Employee Retirement Income Security Act (ERISA) requires that every employee benefit plan fiduciary and every person who handles funds or other property for the plan to be bonded. ERISA's bonding requirements are intended to protect employee benefit plans from risk of loss due to fraud or dishonesty on the part of persons who "handle" plan funds or other property.

Is an ERISA fidelity bond the same thing as fiduciary liability insurance?

No. Section 412 of ERISA neither requires nor pertains to fiduciary liability insurance. This type of professional liability insurance specifically covers plan fiduciaries, or those who hold the funds of others under their "care, custody or control." Fiduciaries have a legal obligation to act in the best interests of plan participants; fiduciary liability insurance covers the plan for losses that occur when a fiduciary breaches those responsibilities.

Although Section 412 of ERISA requires a "fidelity bond," the insurance industry now calls this type of coverage an employee dishonesty or employee theft bond.

This type of coverage specifically insures a plan against losses due to fraud or dishonesty on the part of persons (including, but not limited to, plan fiduciaries) who handle plan funds or other property. "Fraud or dishonesty" include, but are not limited to, larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, wrongful conversion, willful misapplication, and other acts where losses result. The bond must cover losses even when the person committing the act receives no gain and even if the act is not subject to punishment as a crime or misdemeanor, if a

ERISA—continued on Page 3

This Just In…

A majority of employers (69 percent) think healthcare reform will lead to higher costs for benefits. An even larger percentage (71 percent) think it will lead to higher costs for U.S. healthcare services overall, found a recent survey conducted by Towers Watson and the National Business Group on Health (NBGH).

A review of studies by researchers with the NBGH and the Pacific Group on Health in San Francisco concurred that current reform proposals do not address all leading causes of healthcare waste. The report, *Better U.S. Health Care at Lower Cost,* listed: providing unnecessary services, using inefficient delivery methods, lack of price competition, excessive administrative costs in the provider and insurance sectors, and "missing opportunities to lower net spending via illness and injury prevention."

The report highlights specific tools that can help trim waste from the system, including adoption of electronic health records (an estimated $77 billion annually), expanding the availability of quality end-of-life and palliative care for serious advanced illness ($6 billion), and motivating healthcare providers to attain certain performance benchmarks, which would also reduce mortality rates. You can find the report at www.issues.org/26.2/milstein.html.

Deadline to Meet Parity Requirements Coming!

All group health plans covering more than 50 employees must comply with the Mental Health Parity and Addiction Equity Act of 2008 by October 1, 2010. Here's what you need to know.

If you've been handling employee health benefits for a while, you might remember previous rules requiring "mental health parity" in group health benefits expiring at year-end, only to be renewed. The latest parity law, the Mental Health Parity and Addiction Equity Act of 2008, removed automatic sunset provisions and expanded parity requirements.

What it covers

Under previous parity laws, group health plans had to provide the same annual and aggregate lifetime limits, "financial requirements" and treatment limitations to mental health benefits as they did to medical and surgical benefits. Under the 2008 law, the parity requirements now extend to substance abuse benefits.

The Act applies to employers with more than 50 employees that offer group health plans that include mental health and/or substance abuse benefits along with medical/surgical benefits. If your plan does not provide benefits for mental health or substance abuse, the Act does not require you to provide them.

The Act generally prohibits group health plans from placing stricter coverage limits or lower financial limits on mental health or substance abuse benefits than on medical/surgical benefits. Specifically, plans cannot 1) impose higher financial requirements (such as deductibles and copayments), 2) put stricter treatment limitations (number of visits or days of coverage), or 3) impose separate cost-sharing requirements or treatment limitations to mental health/substance abuse benefits. It requires plans to provide for out-of-network mental health/substance abuse benefits if it provides out-of-network medical/surgical benefits, and to make standards for "medical necessity" determinations and reasons for any denial of mental health/substance abuse benefits available upon request to participants.

The U.S. Departments of Health and Human Services, Labor and the Treasury released proposed rules to implement the Act in January. These rules further clarify plan sponsors' duties under the Act. Although not final, the final rules will likely be similar. The proposed rules clarify the following changes employers should be aware of:

- **Treatment by specialists:** Health plans commonly require higher copayments for treatment from a specialist, such as a cardiologist, than from a primary care provider. Some health plans identify a large range of mental health and substance use providers as "specialists." The regulations do not allow the separate classification of mental health generalists and specialists in determining the copayments and other financial requirements, because allowing plans to provide less favorable benefits for services by these providers than for services by medical/surgical primary care providers would undercut the protections that the statute was intended to provide.
- **Separate or combined deductibles?** Some plans have separate cumulative financial requirements for different classifications of benefits. For example, your plan might have separate annual deductibles for pharmacy benefits and medical/surgical benefits, particularly if it uses a pharmacy benefit manager to provide prescription drug benefits. Likewise, many plans use a separate managed behavioral health organization (MBHO) to provide mental health benefits.

  The law did not specify whether a plan could have "separate but equal" cumulative financial requirements, such

DEADLINE—continued on Page 3

DEADLINE—continued from Page 2

as deductibles and out-of-pocket limits. However, regulators determined that a plan may not apply cumulative financial requirements or cumulative quantitative treatment limitations to mental health or substance abuse benefits.

- **Employee assistance programs (EAPs):** Rulemakers also prohibited requiring participants to exhaust the EAP benefits—making the EAP a gatekeeper—before an individual is eligible for the major medical program's mental health or substance use disorder benefits. They ruled this is a treatment limitation subject to parity requirements and thus prohibited.

New interim final regulations will be effective 60 days after they are published, or April 5, 2010. We can help you review your plan documents to ensure your plan meets the parity requirements. For information, please contact us. ■

ERISA—continued from Page 1

bond providing protection against fraud or dishonesty would afford recovery according to the law of the state in which the act is committed.

How much coverage do we need?

ERISA refers to persons who handle funds or other property of an employee benefit plan as "plan officials." ERISA requires a plan official to be bonded for at least 10 percent of the amount of funds he or she handled in the preceding year, with a minimum bond amount of $1,000 per plan for which the plan official has handling functions. In most instances, ERISA requires a maximum bond amount of $500,000 per plan for any one official. However, effective for plan years beginning on or after January 1, 2008, plans that hold employer securities have a maximum required bond amount of $1 million for plan officials. Bonds cannot have deductibles or other risk-transfer features.

Who needs coverage?

Employers that sponsor plans should ensure they have coverage for employees who have duties relating to the receipt, safekeeping and disbursement of funds. You should also make sure that others who handle plan funds have coverage, such as service providers whose functions involve access to plan funds or decision-making authority that could lead to risk of loss through dishonesty or fraud.

Many employers buy separate coverage to meet the ERISA requirement. However, if you already have employee dishonesty or theft coverage, you can add coverage for ERISA plans, which will likely cost less than buying coverage separately. For more information, please contact us. ■

VOLUNTARY—continued from Page 4

loyalty towards their employer, behind salary and wages (85 percent) and health benefits (71 percent).

All employers, particularly smaller ones, might be reluctant to add expenses during these uncertain economic times. But many employers are missing an opportunity to enhance their benefit programs through voluntary programs, which cost them nothing.

Under a voluntary benefits program, the employer offers employees a menu of benefits; employees select only those they want. Unlike traditional group benefits, voluntary programs require no employer contributions. Employees pay all of the premiums, sometimes on a pre-tax basis (for qualified benefit plans only), through payroll deduction.

While traditional group benefits demand high levels of participation, typically 75 percent, voluntary programs require only 20 percent participation (for most health plans); other voluntary benefits may have no participation requirements.

Another advantage of voluntary benefits is that they are non-discriminatory. Many benefits, such as dependent health and life benefits, dependent care savings accounts and adoption benefits, have value only for those with children or elderly dependents. They're less likely to appeal to young singles, who might see these benefits as favoring older workers with families if the employer pays for them. With voluntary benefits, employees select and pay for only those benefits that they really want.

Save on Payroll Taxes

If you want to enhance your benefit package but think adding group life, dental, disability, critical care or long-term care insurance might be too expensive, take a look at voluntary plans.

Not only will they cost you nothing, employers can actually save money by combining voluntary benefits with a Section 125 salary reduction plan. The Section 125 plan allows employees to pay for qualified voluntary benefits (such as most medical and life benefits) with pre-tax dollars. This reduces their taxable income.

It also reduces the employer's payroll tax liability. Companies with a Section 125 plan can save hundreds of dollars per employee if employees participate in their voluntary benefit plans. In addition to health and life coverages, voluntary benefits include other programs, often called "worksite benefits." These plans can help employees create a better work/life balance and include:

- Prepaid legal plans
- Pet insurance
- Funeral pre-planning services
- Auto and homeowners insurance
- Mortgages and other financial services.

All can be paid by convenient payroll deduction and many of these programs offer savings over what your employees can find on their own. For more information on voluntary benefits, please contact us. ■

The information presented and conclusions within are based upon our best judgment and analysis. It is not guaranteed information and does not necessarily reflect all available data. Web addresses are current at time of publication but subject to change. This newsletter is FINRA-compliant; Smart's Publishing does not engage in the solicitation, sale or management of securities or investments, nor does it make any recommendations on securities or investments. This material may not be quoted or reproduced in any form without publisher's permission. All rights reserved. ©2010 Smart's Publishing. Tel. 877-762-7877. www.smartspublishing.com 30% total recycled fiber. Printed in the U.S. on U.S.-manufactured paper.

Voluntary Benefits Meet Diverse Employee Needs

Small businesses might be missing an opportunity to enhance their benefit programs and employee loyalty!

In a 2009 survey by the nonprofit International Foundation of Employee Benefit Plans, 84 percent of employers responding said they offered some type of voluntary benefit. An additional 5 percent planned to offer them.

Most employers use voluntary benefits to enhance their life and health benefit portfolio, as reflected in the benefits most frequently offered by employers who offer voluntary benefits:

- Term life, 73 percent
- Vision insurance, 53 percent
- Long-term care insurance, 51 percent
- Long-term disability insurance, 50 percent
- Accident insurance, 49 percent
- Dental insurance, 48 percent.

Source: Top Trends in Voluntary Benefits, 2009. International Foundation of Employee Benefit Plans

The 2009 MetLife Study of Employee Benefits Trends found that while small businesses offer medical insurance at about the same rate as larger companies (95 percent and 96 percent respectively), the gap widens for other products. For example, only 65 percent of businesses with fewer than 500 employees offer dental insurance, compared to 93 percent of those employers with 500 or more employees.

This occurs despite the fact that two-thirds of workers at companies with fewer than 500 employees report that benefits such as life, disability and dental insurance contribute significantly to their feelings of

VOLUNTARY—continued on Page 3

ERISA and Your Voluntary Benefits

ERISA, the Employee Retirement Income Security Act, governs any "employee welfare benefit plan" that is "established or maintained by an employer" for the purpose of providing benefits to the plan's participants and their beneficiaries. This includes some, but not all, voluntary plans, despite the fact that the employer may not make a single dollar contribution to the plan.

Intent doesn't determine whether ERISA governs a voluntary plan or not. As a result, you may create an ERISA plan unknowingly and learn about it only after a lawsuit is filed.

What's So Bad About ERISA?

One of the basic purposes of ERISA is to protect promised benefits. To help accomplish that goal, the statute and regulations require sponsors of ERISA plans to provide summary plan descriptions (SPDs), adhere to ERISA claims procedures, and to file an annual Form 5500 financial status report. These, and other requirements, make administering an ERISA plan more complex than other plans.

Compliance Scorecard

By understanding ERISA rules, you can structure your plans to ensure compliance and keep your company out of hot water. Plans that do not fall under ERISA avoid ERISA's fiduciary provisions and do not require SPDs, ERISA claims procedures or Form 5500 filings.

To determine whether your voluntary plan falls under ERISA, start with the Department of Labor's rules detailing "safe-harbor exemptions" from ERISA regulations. To fall within the safe harbor:

1. The employer can make no contributions.
2. Employee participation must be voluntary.
3. The employer's function must be limited to collecting premiums through payroll deductions and remitting them to the insurer.
4. The employer cannot receive consideration in connection with the program (other than reasonable compensation for administrative services performed).

In addition, to avoid problems, employers must avoid all actions that could lead employees to believe the plan is employer-sponsored. For information on ERISA compliance, please contact us.