

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



Medical Benefits

July 2010

Volume 8 • Number 7

Healthcare Reform: Are You Ready for 2011 Plan Changes?



It's time to institute changes to your employee health plan resulting from this year's historic Health Care and Education Reconciliation Act. Because benefit plan design must be finalized, enrollment materials prepared and distributed, and open enrollment concluded well in advance of the first day of the plan year, now's a great time to turn your attention to these details:

★ **Advance Notice of Benefit Changes** – Group health plan participants must be notified 60 days in advance of any material changes in plan terms – by November 1, 2010 for the plan year beginning January 1, 2011. Material changes include changes to covered services, as well as deductibles and co-payments. Because the new advance notice requirement is in addition to existing ERISA disclosure re-

quirements, you may also want to ensure that your required notice meets ERISA requirements for a summary of material modifications.

★ **Dependent Coverage for Adult Children** – Group health plans that provide dependent coverage must allow coverage for children (whether or not married) until they turn 26, even if they do not meet dependency requirements for a tax exemption. To be eligi-

ble, children must not qualify for their own employer coverage. Calendar-year group health plans should be amended to include coverage for adult children and a coordination of benefits provision for those who may be eligible for both parents' plans on or before December 31, 2010 for a January 1, 2011 implementation date.

★ **No Pre-existing Condition Exclusions** – Group

This Just In...

Your organization may be able to cut costs with the Affordable Health Care Act's reinsurance program for early retirees, now available. The Act provides \$5 billion in financial assistance to help employers maintain coverage for retirees age 55 and older who are not yet eligible for Medicare. Both self-funded and insured plans can participate.

Employer and union plans must submit an application to the federal Health and Human Services Department (www.hhs.gov) to participate. Approved plans can submit paid claims to HHS. Many plan managers are already familiar with the similar process for submitting applications for the Retiree Drug Subsidy program. Applications are expected to be available this summer.



REFORM—continued on Page 3



It's Time for a Mid-Year 401(k) Tune-Up

Mid-year is a great time to give your 401(k) plan a little routine care and maintenance. Here's how.

A mid-year review will help you catch any plan errors or overlooked updates that might affect the retirement income of one or more of your employees or subject your organization to regulatory penalties. Here's a quick run-down of how to check under the hood of your 401(k) plan:

Healthcare Reform Action Checklist

- ✓ Prepare for open enrollment and the implementation of requirements scheduled to take effect for your next plan year.
- ✓ Educate employees on what the new laws mean to them and their coverage.
- ✓ Inform employees that adult children under age 26 previously ineligible for coverage will become eligible if they don't qualify for employer coverage.
- ✓ Inform employees that under age-19 children whose pre-existing conditions were not previously covered will be covered under the new law.
- ✓ Inform employees that people whose coverage was capped under previous lifetime limits will become eligible for coverage.
- ✓ Prepare for changes to flexible spending accounts or health reimbursement arrangements.
- ✓ Create a mechanism to track the value of employer-provided coverage so you can report it on 2011 W-2s.
- ✓ Confer with your broker, legal counsel, insurer or administrator about health plan redesign and/or cost sharing, including HDHPs. ■

- * Laws related to retirement plans change quite frequently, and the IRS generally establishes firm deadlines for adopting these changes. Update your calendar tickler to remind you when amendments must be completed. Maintain regular contact with the company that sold you the plan to ensure you're getting the latest updates.
- * Perform a review of compensation definitions and provide training for the person or people in charge of determining employee/participant compensation. This will help you make sure your plan's definitions of compensation are correct for deferrals and allocations.
- * To ensure you make employer matching contributions correctly for all eligible employees, review your plan document to determine the correct matching contribution formula and compare that

to what's being used. Ensure that your plan administrator has the necessary employment and payroll records to make the calculations.

- * Initiate an independent review to determine if highly compensated and non-highly compensated employees are properly classified. This will help you satisfy the actual deferral percentage (ADP) and actual contribution percentage (ACP) nondiscrimination tests.
- * Review payroll records to extract the total number of employees, birth dates, hire dates, hours worked and other pertinent information to ensure all eligible employees identified are given the opportunity to make an elective deferral. Also inspect W-2 and state unemployment tax documents to see if employee counts are accurate. If an employee was not provided the opportunity to make an elective deferral, make a qualified non-elective contribution (QNEC) to the plan on the employee's behalf.
- * Provide your plan administrator with sufficient payroll information and inspect deferral amounts for plan participants to make sure elective deferral distributions do not exceed amounts allowed under IRC section 402(g) for the

401(k)—continued on Page 3





401(k)—continued from Page 2

- calendar year (\$16,500 for 2010).
- ✦ To ensure timely deposits of employee elective deferrals, coordinate closely with your payroll provider to determine the earliest date the deferral deposits can be segregated from general assets, then set up procedures to ensure deposits are made by that date.
 - ✦ If your 401(k) plan is determined to be “top-heavy,” make employer contributions of up to three percent on behalf of all non-key employees still employed on the last day of the plan year. A plan is top-heavy when, on the last day of the preceding plan year, the aggregate value of key employees’ plan accounts exceeds 60 percent of the aggregate value of the plan accounts for all employees under the plan.
 - ✦ Reacquaint yourself and plan administrators with hardship provisions designed to help employees who are facing immediate or heavy financial need. Share information between plan administrators and payroll offices regarding hardship distributions made from the plan.
 - ✦ Ensure timely filing of required reports, including Form 5500 (*Annual Return/Report of Employee Benefit Plan*) and the Summary Annual Report (SAR), which goes to all plan participants annually. Don’t assume someone else is filing these forms. Each plan may have a number of individuals providing service to the plan, including your CPA, the TPA, benefits attorney, auditor, inside auditor, human resource employees, banker and financial advisor. The plan administrator should have the responsibility for making certain the return is properly filed.

Finally, if you have any questions or concerns, opt for an independent review of your plan administration. Then develop communications protocols to make all relevant parties aware of changes on a timely and accurate basis.

For more information on 401(k) plan administration or setup, please contact us. ■

REFORM—continued from Page 1

- health plans may not impose pre-existing condition limitations on children under the age of 19. Calendar year group health plans should be amended to reflect this on or before December 31, 2010 for a January 1, 2011 implementation date.
- ✦ **Prohibition on Rescission** – Group health plans may not rescind coverage except in cases of plan-defined fraud or misrepresentation. In addition, if a sponsor wishes to exercise the right to rescind coverage for fraud or misrepresentation, the plan must specifically provide for this action, which requires advance notice. Calendar-year group health plans should be amended in this regard on or before December 31, 2010 for a January 1, 2011 implementation.
 - ✦ **Medical expenses covered by FSAs and HRAs** – Medical expense flexible spending accounts (FSAs) or health reimbursement arrangements (HRAs) may no longer reimburse for over-the-counter drugs effective January 1, 2011. This change returns to rules that existed before 2003. To the extent this is a material change to an employer’s current plan design, the employer needs to provide ad-

vance notice by November 1, 2010 for the plan year beginning January 1, 2011. In addition, calendar-year flexible spending account plans and health reimbursement arrangements should be amended in this regard on or before December 31, 2010 for a January 1, 2011 implementation.

- ✦ **W-2 reporting** – While W-2 reporting for the 2011 calendar year seems a long way off, employers will need to compile records from the beginning of 2011 to produce the required report. Beginning with the 2011 W-2, employers or their payroll providers will need to report the aggregate cost of employer-sponsored coverage provided to the employee, determined using COBRA premium rates and including the employee-paid portion. This reporting requirement is only the first of a number of additional reporting requirements. Others become effective in later years; we will inform you of those changes in future newsletters.

If you have questions on the new health plan changes, please contact us as soon as possible to ensure your plan complies. ■

LONG-TERM CARE—continued from Page 4

requires the Health and Human Services Secretary to release the details of the plan no later than Oct. 1, 2012. So it is likely that people will be able to sign up sometime after that — in 2012 or 2013.

You don’t have to decide right away how to implement the CLASS program in your organization, if at all. However, some of your employees will want to know what you plan to do, particularly those now enrolled in private long-term care plans or facing imminent long-term care needs.

The government projections call for five percent participation, which means you’ll have to go through a lot of work and cost to educate the 95 percent of your employ-

ees likely to opt out if you do decide to participate.

If you don’t currently offer long-term care benefits, you can consider offering the CLASS program either with or without private long-term care plans. There are significant differences between private long-term care insurance and the CLASS program. A private long-term care plan can be tailored to your employees’ needs, with higher benefits than available under the CLASS program, which is one-size-fits-all.

At the very least, passage of the CLASS Act could spur employee awareness of long-term care needs and benefits. ■



Does the CLASS Act Solve the Long-Term Care Crisis?

Currently, millions of older adults who have worked hard all their lives are forced to spend down their life savings and go into a nursing home, just because they can't afford care at home. A provision in the health care overhaul law signed by President Barack Obama could bring help.



According to an article in the January 2010 issue of the journal *Health Affairs*, nursing home costs in the U.S. average more than \$75,000 per person per year, or \$250 per day.

The Community Living Assistance Services and Support Act (CLASS Act) is designed to make it easier for individuals who need long-term care to get care in their own homes, without spending down their assets to qualify for Medicaid.

The CLASS Act brings financial relief to those requiring assistance with activities of daily living by establishing a national voluntary insurance program for purchasing community living assistance services and supports. The plan will provide cash to en-

rollees who suffer at least two limitations in daily activities, such as eating, bathing and dressing.

Only people who are currently working can enroll, and they must opt to pay in. If their employer chooses to participate, they can pay the premiums through payroll deduction. After paying in for five years, participants will be eligible to earn an average of \$75 per day in cash on a monthly benefit basis to help them pay for home and community-based care.

The Congressional Budget Office estimates that the monthly insurance premium will average about \$123 in 2011. Premiums vary with age and will not increase once enrollees sign up, but they will increase for those signing up later.

About 10 million Americans currently need long-term care services, including four million under age 65. Supporters say the CLASS program will give families greater means to care for disabled relatives.

Some business and insurance groups, however, argue that the CLASS program won't be financially sustainable unless enough Americans sign up for it; the larger the pool, the more successful the program.

What it means for you

Neither employees nor employers must participate in the program. And employers may pay all or part of the premiums but are not required to do so.

While most provisions of the CLASS Act are "effective" January 1, 2011, the law

LONG-TERM CARE—continued on Page 3

CLASS Act Fast Facts:

- ✓ The CLASS Act is a voluntary federal program financed by participant premiums without any federal subsidy.
- ✓ Any American age 18 or over who meets an actively-at-work requirement can participate.
- ✓ Monthly premiums are charged based on age at enrollment and year of enrollment. Premiums are intended to be level over an individual's lifetime; however, the secretary of Health and Human Services can increase premiums if it is determined necessary for the financial health of the program.
- ✓ Individuals must pay premiums for a 60-month vesting period before they can receive benefits.
- ✓ The program provides a cash benefit of at least \$50 per day, indexed to the consumer price index (CPI), for an impaired individual living in the community, and up to \$75 per day for those in a care facility.
- ✓ To qualify for benefits, an individual must be unable to perform at least two or three activities of daily living or be cognitively impaired.

CLASS Act Action Checklist

- ✓ If your organization will be participating in the program, update your administrative and payroll systems and procedures.
- ✓ Remit enrollment information and premiums to the CLASS program trust fund.
- ✓ Communicate the financial reality of long-term care costs and coverage opportunities.
- ✓ Contact us for more information on private long-term care insurance, which can be written on an entirely voluntary (employee-paid) basis. ■