



# MID AMERICAN GROUP

"The Leading Edge"

A quarterly Newsletter to our valued friends and clients...

Winter, 2004

Ask us about...

## The Leading Edge

...a trend-setting employee benefits program from Mid American Group, including:

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- ⇒ COBRA Administration
- ⇒ Flex Administration
- ⇒ Benefits Administration
- ⇒ Cafeteria Plan Administration
- ⇒ HIPAA Administration

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The information contained in this publication is intended for the general information of our clients. It should not be construed as legal advice or legal opinion regarding any specific or factual situation.

## MEDICARE LAW GIVES NEW TAX-FAVORED PLAN – HSA

The new Medicare Prescription Drug, Improvement and Modernization Act of 2003 delivers a new health care funding vehicle, the Health Savings Account or HSA. **A health savings account (HSA) combines some of the features of flexible spending accounts, health reimbursement arrangements (HRAs) and medical savings accounts (MSAs).** These new accounts can be effective as soon as January 1, 2004. Whether HSAs will replace one or more of these various benefit vehicles remains to be seen.

**An HSA is a trust account that is tied to a specifically defined high deductible health plan (HDHP).** A trustee can be a bank, an insurance company or another person. The Secretary of the Treasury will determine a trustee's qualifications. IRS guidance provides that existing IRA or Archer MSA trustees or custodians are automatically approved as trustees.

**An individual owns the trust. As such, their interest in the balance of the account is nonforfeitable. Individual ownership of the account is a significant difference from the "accounts" established under an HRA, which do not have this requirement.**

**HSAs must be coupled with a high deductible health plan (HDHP). An HDHP is a health**

**plan featuring:**

- **Individual deductible of at least \$1,000.**
- **Family deductible of at least \$2,000.**
- **Out-of-pocket limits of no more than \$5,000 (individual) or \$10,000 per family. These amounts will be adjusted for inflation in 2005.**
- **A smaller deductible, or no deductible, is required for preventive care.**
- **Deductible and out-of-pocket limits can be higher for out-of-network services.**

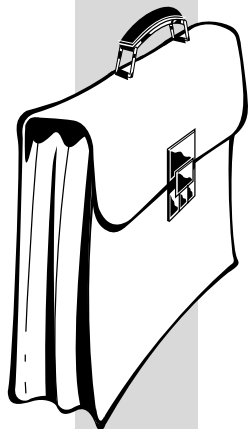
**Contributions to HSAs are allowed up to 100% of the health plan deductible. The maximum contribution is indexed for inflation with initial limits of \$2,600 for individual policies and \$5,150 for families.** The deduction is prorated equaling the associated number of months elapsed. Therefore, someone participating in a plan for 6 months would only have one-half of the above noted limits available.

Borrowing an idea from pension reform, individuals age 55-65 can make "catch up" contributions. These are \$500 in 2004, gradually increasing to \$1,000 in 2009.

**Contributions are tax-deductible. The deduction for individuals is an above-the-line deduction, a benefit for those who otherwise do not itemize on their tax returns.**

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## News Briefs



### MEDICARE DRUG BENEFIT ARRIVES IN 2006

The new Medicare prescription drug benefit will be effective in 2006. Congress believed that it was important to keep consumers engaged in their purchasing decisions by having them share in the costs. In keeping with this mindset, Medicare supplement plans cannot include covered prescriptions once the benefit is available.

**The drug plan will be a stand-alone plan with a premium of \$35. After a \$250 deductible, the beneficiary will pay 25% of drug costs up to \$2,250. The corridor – or donut as some have called it – of \$2,250 to \$3,600 is an out-of-pocket limit. Drugs after this limit require a 5% copayment.**

Congress has also included a test where Medicare will compete with private plans. This test will begin in 2010.

### FSA CLARIFICATION INCLUDED IN MEDICARE DRUG LAW

During 2003, the IRS ruled that over the counter drugs (OTCs) could be reimbursed through flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs). However, they included a requirement that employers would have to file Form 1099 reports to vendors with payments in excess of \$600.

Given the many sources for over the counter drugs (OTCs), employers feared that this reporting requirement would prove onerous. **The new Medicare law drops this 1099 reporting requirement for payments made after December 31, 2002 (retroactively).**

**Employers must amend their FSA plans if they wish to include over the counter drugs (OTCs).** Once a plan has this provision, employers can expect that employees will no longer have amounts forfeited at the end of the year – it will be too easy to go to the drug store and stock up on antacids and aspirins. Therefore, employers can no longer count on these forfeited amounts to offset the costs of their plans.



### HEALTH COST TRENDS SLOW IN 2003

It appears that employer efforts to reign in prescription drug costs have been effective. An analysis of health costs by the Center for Studying Health System Change reports that spending growth for privately insured Americans slowed in the first half of 2003. **Prescription drug spending slowed the most, rising 5% less than the second half of 2002 (8.5% versus 13.4%).**

Hospital prices are putting additional pressure on costs. **However, hospital utilization trend has slowed to offset the increased pricing.** Analysts believe that increased patient cost sharing has helped slow utilization.

**The analysts caution that the moderating trends, while a welcome respite, do not signal an end to large health cost increases.** They caution that employers and others will have to continue to find effective measures to control costs and utilization if health care is to be affordable.

### WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE REQUIRED

Employer plans are required to provide an annual notice to plan participants regarding the Women's Health and Cancer Rights Act of 1998. A model notice is available through the federal Department of Labor at [www.dol.gov/ebsa/publications/whcra.html](http://www.dol.gov/ebsa/publications/whcra.html).

## HIPAA COMPLIANCE FOR SMALL PLANS DUE APRIL 14, 2004

Small health plans, defined as those with receipts of under \$5 million dollars, are required to comply with HIPAA's Privacy Rule beginning April 14, 2004. Many employers are already familiar with these requirements because of actions taken by health care providers and health insurers.

All covered health plans must also have Business Associate Agreements and arrangements in place by the April 14, 2004 deadline. **Business Associate Agreements require that vendors who receive PHI (Protected Health Information) meet the requirements of HIPAA Privacy.**

## WATCH OUT FOR MEDICAL STOP LOSS ASSESSMENTS

With most states facing continued budget deficits, legislators are looking for new entities to tap for revenue. **Self-insured employers have been targeted by several states as a new revenue source through a tax on medical stop-loss premiums.**

States that have been the most aggressive in seeking

legislation to tax medical stop-loss plans want the monies to offset losses in their high-risk pools for the uninsured. Frequently, the high-risk pools are funded through assessments on health insurers doing business in the state. Self-funded employers have not been helping to fund these pools since they are not purchasing insurance.

Several states have been pursuing these new taxes, including Colorado, Indiana, Mississippi, Wisconsin and others. **The assessments can add 15% and more to the cost of medical stop-loss coverage.**

Whether states can legally assess medical stop-loss plans for funds is uncertain. **ERISA's pre-emption clause does not allow states to regulate self-funded plans.** However, advocates for employers believe that it is better to prevent assessments from being enacted than to fight the pre-emption issue through the courts.



## NEW SPLIT DOLLAR LIFE INSURANCE RULES

Life insurance policies purchased after September 17, 2003 are subject to the new rules for split-dollar life plans. **IRS final rules regarding these plans provide that taxation depends on who owns the policy.**

**For employee owned policies, employer-paid premiums are deemed to be loans. Employees are taxed based upon the imputed interest rules. If the employee does not pay the market rate interest, then the employee can be taxed on the difference between the market rate and the actual rate. If the amounts are not subject to repayment, then the premiums are taxed as income to the employee.**

**When employers are owners of the policies, the value of the policy is taxable to the employee. The covered executive is taxed based on their economic interest, if any, in the policy's cash value and the current life insurance protection.**

The transition rules for split dollar plans entered into before January 28, 2002 expired on December 31, 2003.

## NEW RETIREMENT PLAN LIMITS FOR 2004



	2004	2003
401(k), 413(b), 457 Plan Elective Deferral Limit . . . .	\$ 13,000	\$ 12,000
Defined Contribution Limit . . . . .	\$ 41,000	\$ 40,000
Compensation Limit . . . . .	\$ 205,000	\$ 200,000
Defined Benefit 415 Limit . . . . .	\$ 165,000	\$ 160,000
"Catch Up" Contribution Limit . . . . .	\$ 3,000	\$ 2,000



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**NEW TAX-FAVORED PLAN - HSA** *continued from page 1*

**Employer contributions, if applicable, are not taxable to the employee. Employer contributions will be subject to a non-discrimination requirement.**

Salary reductions are also eligible for contributions through a cafeteria plan (Section 125 plan). All forms of contributions are exempt from federal income taxes. **Employer and salary reduction contributions are exempt from FICA and FUTA payroll taxes.**

HSAs are modeled on Medical Savings Accounts (MSAs). Congress did not apply many of the regulatory burdens that hampered MSAs to HSAs. MSA plan designs required a deductible of at least \$1,700 and \$3,450 for individual and family coverages respectively. The HDHP for HSAs is more modest at \$1,000 and \$2,000.

**Funding for HSAs is more flexible than for MSAs. Employer contributions or employee contributions, but not both could fund MSAs. HSAs can be funded by one or both of these, as well as through a salary reduction under a cafeteria plan.**

An excise tax is applicable for either type of plan if distributions are made for non-health purposes. But, the HSA penalty is 10%, versus 15% for MSAs.

**One of the biggest issues for employers is likely to be that these accounts are owned by the individuals and must be funded on an ongoing basis. HRAs can be funded as claims are submitted and, depending on the design of the plan, may be subject to forfeiture if employment terminates.**

The ERISA status of the plans is unclear and may depend on the level of control that an employer wishes to exert. If an employer provides a HDHP and allows employees to establish an HSA on their own, ERISA will likely not apply to the HSA account.

However, if an employer wishes to establish restrictions on the types of medical expenses that can be reimbursed or how a claim must be substantiated, then ERISA may come into play.

The IRS provided additional guidance on HSAs in December 2003. They plan to provide additional guidance in the summer of 2004.