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Inside this issue:

Health Insurance Exchanges	1
FSA's Use it or Lose It	2
1099 Provision Repeal	3
ADAAA	3
Compliance Corner	4

Health Insurance Exchanges Already Making Waves

It seems like a simple idea: create new marketplaces, called “exchanges,” where consumers can comparison shop for health insurance, sort of like shopping online for a hotel room or airline ticket.

But, like almost everything else connected with the health overhaul law, state insurance “exchanges” are embroiled in politics. Some Republican governors are threatening to refuse to set up exchanges unless they get more flexibility over Medicaid, the state-federal health program for the poor. Others say they don’t want to implement any part of the federal health care law.

Louisiana officials decided against setting up an exchange. And in Montana, GOP lawmakers killed GOP-sponsored Senate bill to set up an exchange. Still, some Republican officials are embracing them. And consumer advocates, disease groups and industry lobbyists are jockeying for influence over how the exchanges will be regulated.

If done well, proponents say, exchanges could make it easier to buy health insurance and possibly lead to lower prices because of increased competition. But, if designed poorly, experts warn, healthy people could avoid the exchanges, leaving them to sicker people with rising premiums.

Here are some common questions:

Q. What is an exchange, as envisioned by the health law?

A. It’s a marketplace where individuals and small employers will be able to shop for insurance coverage. They must be set up by Jan. 1, 2014. The exchanges will also direct people to Medicaid if they’re eligible.

Q. Will all states have exchanges?

A. States have the option of setting up their own exchanges, forming coalitions with other states to create regional exchanges—or opting out altogether. In that case, the federal government will run the exchanges for their residents.

Q. Will anyone be allowed to buy from the exchanges?

No. Initially, exchanges will be open to individuals buying their own coverage and employees of firms with 100 or fewer workers (50 or fewer in some states). Most Americans will continue to get insurance through their jobs, not via the exchanges. The Congressional Budget Office estimates 8 million people will use the exchanges in 2014 and 24 million in 2018. Most will be people who are eligible for subsidies, which will average an estimated

\$5,700 person. Undocumented immigrants will be barred from the exchanges.

Q. What about federal workers?

A. Members of Congress and their staffs will be required to buy through exchanges if they want coverage from the federal government. Other federal employees won’t be required to use an exchange.

Q. Will exchanges be like travel websites or some existing health insurance sites?

A. In some ways. People will be able to compare policies sold by different companies. But information on the plan benefits will be standardized to make it easier to compare cost and quality plans will be divided into four different types, based on the level of benefits: bronze, silver, gold and platinum.

Q. What will the coverage sold on the exchanges look like?

A. Plans will have to offer a set of “essential benefits.” Those details, still being developed by the Obama administration, will include hospital, emergency, maternity, pediatric, drug, lab services and other care.

Continued on page 4...

Bill Seeks to End FSA “Use It or Lose It” Rule

“It is truly unfair that families must forfeit hard earned dollars that they have reserved for health expenses if they remain in the account at the end of the year.”

The proposed Medical Flexible Spending Account Improvement Act (H.R. 1004), a bill that would allow employees to withdraw and pay taxes on any remaining funds in their medical flexible spending accounts (FSAs) instead of forcing them to forfeit the remaining balance to their employer, as current rules require, was introduced on March 11, 2011, by Reps. Charles Boustany, R-La., and John Larson, D-Conn.

FSAs are pretax accounts funded by employer contributions that can be used to pay for qualified medical expenses. The IRS adopted the forfeiture, or “use it or lose it,” provision to prevent FSAs from being misused as tax shelters. However, a \$2,500 cap on FSA contributions set to begin in 2013 as required by the Patient Protection and Affordable Care Act eliminates the need for that concern, according to Save Flexible Spending Plans, an advocacy campaign that works to promote the accessibility and use of FSAs.

The proposed bill does not allow unused FSA funds to be rolled over and remain in the employee’s account for the following year. In this regard, FSAs would remain distinct from health savings accounts (HSAs), in which funds may roll over and grow through compounding from year to year. HSAs, however, must be linked to high-deductible health plans, whereas FSAs carry no such requirement.

An ‘Easy Fix’

“As the price of health care continues to climb, FSAs help millions of working Americans manage and hold down their out-of-pocket costs,” said Joe Jackson, CEO of benefits provider WageWorks Inc. “Unfortunately, the ‘use it or lose it’ rule creates an unnecessary risk for FSA participants and a deterrent for non-participants. A change to this rule ensures that individuals will not be forced to use up or forfeit any remaining funds simply because their families’ needs did not match their predicted annual health care expenses.”

He added, “In considering changes to improve our health care system, removing ‘use it or lose it’ is an easy fix.”

Forfeiture Fears

Boustany and Larson echoed that sentiment in a letter to their colleagues in Congress. “Over 85 percent of large employers offers FSAs, but only 20–22 percent of eligible employees enroll,” stated the representatives. “The principal reason for not enrolling, or for underfunding accounts, is fear of the ‘use-or-lose’ provision.”

One-quarter of participants forfeit some of their FSA funds every year, the bill’s sponsors noted.

“Now is the time to finally eliminate the use-or-lose provision,” Larson added in a statement. “It is truly unfair

that families must forfeit hard earned dollars that they have reserved for health expenses if they remain in the account at the end of year.”

Employer Concerns

Some employers responded to the bill’s introduction by noting there is a business case to be made for forfeiture of unused funds. Forfeited funds, they argue, are used by employers to offset the cost of administering the FSA.

In addition, the “uniform coverage” rule requires that employers make the full amount of coverage elected under the plan available to employees from first day of the plan year, regardless of how much an employee has actually contributed to the account through salary deferral. When employees elect the full amount, submit and receive reimbursement up to the annual limit and then leave employment mid-year, the employer is liable for the expenses in excess of the employee’s partial-year contribution. Forfeited funds help offset this cost, which can be substantial, some point out.

Source: Stephen Miller/SHRM

1099-Repeal Act Passed by Senate



The Small Business Paperwork Mandate Elimination Act, H.R. 4 as passed on Tuesday, April 12th which means that small businesses will not be required to use 1099 IRS tax forms to report all transactions greater than \$600 next year. It also affects those who receive rental income in a similar fashion.

Small businesses will soon be free of the onerous 1099-reporting mandate expanded in last year's health care reform legisla-

tion. The U.S. Senate passed The Small Business Paperwork Mandate Elimination Act, H.R. 4, by a vote of 87–12. The bill, which has now been passed by House and Senate, will go to President Barack Obama to be signed. The House of Representatives passed the bill in March.

The bill repeals Section 9006 of last year's Patient Protection and Affordable Care Act in which business owners, starting next year, were going to be required to use 1099 IRS tax forms to report all transactions greater than \$600 each year.

It also repeals a requirement passed in the small-business lending bill in which people getting rental

income must distribute 1099s on payments made in excess of \$600 annually, according to the Small Business & Entrepreneurship Council.

"The universally reviled 1099 provision is almost gone, and with good reason," council President and CEO Karen Kerrigan says. "Small-business owners are incensed that they would be overwhelmed by mind-numbing paperwork when they are already overburdened by government regulation and compliance costs. The provision made absolutely no sense, and small business owners are pleased that most members of Congress see it their way." Obama had called for the measure's repeal during

his State of the Union address in January.

"Small businesses are the engine of our economy and eliminating the 1099 reporting requirement is the right thing to do," according to a White House statement issued on Tuesday, April 12, 2011.

"As we move forward, we look forward to improving the tax credit policy in this legislation to ensure we protect small businesses and middle-class families."

Source: NuWire Investment News

EEOC Issues Regulations Implementing ADA Amendments Act



The Equal Employment Opportunity Commission (EEOC) issued finalized regulations implementing the changes made by the ADA Amendments Act (ADAAA), which went into effect on January 1, 2009. The regulations are intended to simplify the determination of whether an individual has a "disability" for purposes of protection under the ADA. The regulations keep the ADA's definition of the term "disability" as a physical or mental impairment that substantially limits one or more major life activities, a record or past history of such an impairment, or being regarded as having a disability.

One of the most notable changes is that the final

regulations no longer state that certain impairments will consistently be considered disabilities. However, the regulations do still list a number of impairments that usually will be considered disabilities as defined by the ADA, including epilepsy, diabetes, cancer, HIV infection and bipolar disorder.

Importantly, the regulations also adopt "rules of construction" to use when determining whether an individual has a disability. For example, according to the EEOC, the principles provide that an impairment need not prevent or severely or significantly restrict performance of a major life activity to be considered a

disability. Additionally, whether an impairment is a disability should be construed broadly, to the maximum extent allowable under the law. The principles also provide that, with one exception (ordinary eyeglasses or contact lenses), "mitigating measures," such as medication and assistive devices like hearing aids, must not be considered when determining whether someone has a disability. Additionally, impairments that are episodic (such as epilepsy) or in remission (such as cancer) are disabilities if they would be substantially limiting when active.

Among other changes, the regulations also clarify that the term "major life activities"

includes "major bodily functions," such as functions of the immune system, normal cell growth and brain, neurological and endocrine functions. The regulations also make it easier for individuals to establish coverage under the "regarded as" part of the definition of "disability."

These final regulations become effective on May 24, 2011.

Source: National Financial Partners

State Exchanges...Continued from page 1

Q. How much will the policies cost?

A. The premiums will vary by type of plan and location. Insurers won't be able to charge more based on gender or health status. They will be able to charge older people up to three times more than younger ones.

Q. Will the states negotiate premiums with the insurers?

A. The law doesn't require states to set or negotiate premiums. However, states may have some influence over prices. For example, states can decide whether to open exchanges to all insurers, or to limit the number. State insurance commissioners will be able to recommend whether specific insurers should be allowed to sell in the exchange, partly based on their patterns of rate increases.

Q. What if I can't afford the premiums?

A. People who earn less than 133 percent of the federal poverty level, \$14,484 this year, will qualify for

Medicaid in all states, under the law. Above that, sliding scale subsidies for private insurance on the exchanges will be available for residents who earn up to 400 percent of the poverty level, about \$43,560 this year. Most people will be required to have coverage of some sort beginning in 2014.

Q. Will all insurers have to offer policies through the exchange?

A. No. Insurers won't be required to sell through the exchanges.

Q. Will all state exchanges be the same?

A. No. States can design their exchanges differently, an issue that's sparking debate in statehouses nationwide. Some states may choose to set additional standards for insurers beyond the federal law. Another important issue: The makeup and power of the governing boards overseeing the exchanges. Some states, such as Maryland, are considering barring insurance industry and sales agents from their governing boards. Others, like North Carolina, have pending legislation that includes representatives from those groups on their governing boards.

Source: Kaiser Health News

KENTUCKY UPDATE

On March 16, 2011, Gov. Steven Beshear signed HB 255, which amends Kentucky income tax law with regard to the exclusion of the employer-provided health insurance premiums for adult dependent children under age 27. Thus, those employees who have adult children that would now qualify for health insurance under PPACA may receive the same tax treatment for Kentucky state income tax purposes as they would for federal income tax purposes.

Source: NFP

Wellness

A third of firms will try new wellness incentives, up from 7% now. By tying premium credits or cash to healthier behavior, meeting targets for blood sugar, lowering cholesterol...companies hope to save over time. Healthy workers require fewer and cheaper treatments. They are also more productive, missing less work. Look for more employers to go the penalty route too, tacking on surcharges of \$50 to \$100 a month for workers who use tobacco.

Source: Kiplinger

Is there a deadline for contributions to a HSA for a taxable year? What is the allowable limit?



While contributions to an HSA can be made in one or more payments during the taxable year, the deadline to make contributions is prior to the time for filing the eligible individual's federal income tax return for that year (without extensions). For individuals, this deadline for 2010 is April 18, 2011, due to a holiday occurring on April 15, 2011. Despite the April 18, 2011, deadline, employers that fund contributions to their employee's HSAs may want to time the contributions for purposes of its own deduction for the year. Thus, employers

may need to fund those contributions no later than the employer's tax filing deadline (without extensions), and the date will vary depending on the employer's tax structure. For example, a corporate employer would want to make its contribution by its March 15, 2011, tax filing deadline.

Employers can choose to make lump-sum contributions to employee HSAs, but are also permitted to fund pay-period by pay-period contributions or monthly contributions. However, if an employer is funding a contribution for 2010 before the tax filing deadline in 2011, they must notify both the employee and the HSA trustee or custodian that the contributions relate to the prior year. There is no guidance on how this notification must

occur.

HSA contributions made by employers are aggregated with other HSA contributions made by the employee to determine the total allowable contribution. For 2010, the max contribution allowed for individuals with single High Deductible Health Plan coverage is \$3,500 and \$6,150 for family coverage. These amounts may be increased by \$1,000 for individuals who turn age 55 or older during the year as a catch-up contribution. There is also a special rule for married individuals, which provides that if either spouse has family coverage, then both spouses are treated as only having family coverage.

In other words, a married couple may contribute no more

than \$6,150 to an HSA during the year, including any employer contributions. Any available catch-up contributions are not included in this limit. Finally, the HSA limits are calculated on a monthly basis. Therefore, an individual who was not eligible for all 12 months of the year may have a lesser contribution amount and should seek guidance from an accountant in determining the appropriate contribution that may be made, less any employer contributions.

Source: National Financial Partners