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Benefit *Source*

IRS issues new rules for the Benefits Card

Electronic payment cards, such as the Benefits Card offered by BenefitHelp Solutions, can be used at a location with a medical merchant code.

The guidelines allowed electronic verification of card transactions at merchants without a healthcare-related merchant category code as long as an inventory information approval system (IIAS) is in place to ensure that cards are used only for eligible medical care expenses and certain recordkeeping requirements are met.

Verification of certain transactions, such as multiple co-payments at merchants with a healthcare-related merchant category code, is also permitted.

When the auto-verification and IIAS are working, the participant is not required to submit documentation for the covered expense.

Examples of merchants that are considered medical are medical services and health practitioners, drug stores and pharmacies, doctors, dentists and orthodontists.



Merchants that do not fall into the medical category include grocery stores, supermarkets, colleges, universities, department stores and discount stores.

Beginning January 2009, the card can only be used at pharmacies with a medical merchant code and an IIAS in place with the card vendor. This means you can pay for items at the pharmacy register using the Benefits Card only if they have the electronic verification process in place.

The Benefits Card can also be used at grocery and drug stores for over-the-counter items if the merchant has an IIAS in place. The card can also

be used at doctors' offices and medical facilities, but documentation may be required to validate the charges.

Covered expenses at other merchants are still eligible for reimbursement under the flexible spending account (FSA). Instead of using the Benefits Card, members must pay for the service and submit the documentation and claims form for reimbursement.

Personnel Profile

BHS welcomes new Managing Director

Industry veteran Steve Schmidt is BenefitHelp Solutions' new managing director. Steve brings 21 years of benefit experience to BHS and ODS, most recently as UnitedHealthcare's executive director for the Northwest.



His diverse skill set ranges from leveraging technology to creating market-leading strategies.

We're all excited to take BHS to the next level of performance under Steve's leadership. Steve looks forward to meeting with many of you to exchange ideas and help your

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Flexible spending account plans and COBRA

Flexible Spending Accounts (FSAs) for healthcare are considered a benefit plan and are subject to COBRA regulations. If an employer had 20 or more employees on a typical day during the prior calendar year, their healthcare FSA plan participants have COBRA rights.

There are two types of FSA plans, qualified and nonqualified, and the COBRA rules are different for each type of plan.

Qualified Healthcare FSA

The most common plan design, a Qualified Healthcare FSA meets the following conditions:

- › The maximum annual benefit for a class of employees cannot exceed two times the participant's payroll deduction for the plan year or, if greater, the participant's payroll deduction for the plan year plus \$500.
- › Participants must be offered other group health plan coverage, not limited to benefits that are accepted benefits under HIPAA (such as vision and limited-scope dental).

A Qualified Healthcare FSA has limited COBRA obligation.

- › To be eligible for COBRA, the FSA account must have a positive balance. This means the claims paid to date do not exceed the contributions made to date.
- › When the FSA plan year ends, the qualified COBRA FSA coverage ends. The COBRA-qualified beneficiary is entitled to the same grace period and run-out period provided by the plan.

- › The COBRA continuant does not have the right to enroll in a subsequent FSA plan year. Any unused FSA funds are forfeited to the employer. COBRA continuants who are paid more than they contributed to the FSA plan are not required to pay the employer back under the Uniform Coverage Rule.

Nonqualified Healthcare FSA

A Nonqualified Healthcare FSA does not meet the Qualified Healthcare FSA conditions:

- › The maximum annual benefit for a class of employees exceeds two times the participant's payroll deduction for the plan year or exceeds the participant's payroll deduction for the plan year plus \$500.

AN EXAMPLE: A Healthcare FSA plan with contributions made by the employer that are greater than \$500.

- › Participants are not offered other group health plan coverage.

AN EXAMPLE: An employer that does not offer medical coverage to employees, offers coverage only to a specific class of employees or offers coverage only when an employee is first eligible.

A Nonqualified Healthcare FSA contains the following COBRA obligations:

- › To be eligible for COBRA, the FSA account must be offered to all FSA participants regardless of the account balance.

WHAT THIS MEANS: The account must be offered even if the

participant has submitted claims that exceed the year-to-date contribution amount.

- › When the FSA plan year ends, the qualified COBRA FSA is entitled to the same grace period and run-out period provided by the plan. Participants also are entitled to open enrollment rights at that time.

WHAT THIS MEANS: COBRA continuants can enroll for the next plan year and can change their annual election amount.

Election rights under COBRA

Under COBRA, each continuant has a separate COBRA election right. This means that a divorced spouse can elect FSA COBRA separate from the participating ex-spouse. The COBRA continuant is entitled to the full balance remaining in the account, which creates a second and equal account. A second qualifying event, such as a dependent reaching the maximum age, can result in another election right and another separate account.

If the qualified beneficiaries elect COBRA, they pay the monthly contribution amount and may be charged an additional 2 percent administration charge.

The COBRA-qualified beneficiaries has the same rights as a similarly situated active employee and can submit claims up to the full annual election (Uniform Coverage Rule) for services incurred while participating in the plan. The COBRA continuant continues to be a participant by paying the monthly premiums.

Healthcare FSA designs can reduce risk

Healthcare FSAs can be designed to reduce the risk to the employer. The primary risk under COBRA is that a COBRA continuant will submit expenses that exceed the contributions to date and then drop COBRA coverage.

Most employers make the decision to offer a FSA regardless of the risk. Understanding how FSA plans work under COBRA can help minimize your company's risk.

Plan documents

The plan documents should include how COBRA continuation will be administered.

One option that may reduce the risk is to state that the COBRA FSA election is an irrevocable election and is subject to the same qualified status change rules as active employees. COBRA FSA continuants cannot drop the FSA and stop paying their FSA premiums unless they have a qualified status change that is consistent with the change.

COBRA continuants could still spend down their account and drop COBRA by not paying their premiums. Depending on the plan design, nonpayment of the premium could mean participants lose medical and dental coverage along with their FSA.



Most plans allow the COBRA FSA continuants to drop their FSA account at any time during their COBRA continuation period, regardless of whether they have a qualified status change, by providing a written request to the plan administrator. This option allows the conscientious participant to avoid losing the money they have contributed by giving them time to incur charges that will use their contribution amount, but exposes the employer to the Uniform Coverage Rule.

Medical plan enrollment

Another way to reduce the risk of a terminated employee electing FSA COBRA and submitting claims that

exceed their contributions-to-date is to include enrollment in the group medical plan as an eligibility requirement for enrollment in the Healthcare FSA. This stipulation would require the COBRA-qualified beneficiary to elect medical coverage in order to elect FSA COBRA coverage.

The costs associated with medical and dental premiums may act as a deterrent to those participants who would like to spend down their FSA account.

The 12-month coverage period

Another way to reduce risk is to design a plan with an irrevocable

See [HEALTHCARE FSA](#), pg. 4

The Uniform Coverage Rule is the primary risk for active participants and for COBRA participants

Employers cannot limit claims reimbursement to the amount that has been contributed. Under IRS rules, Healthcare FSA participants can submit claims up to the full annual election amount at any time during their period of coverage. If the FSA coverage ends before the full annual contributions have been made,

the employer is at risk and cannot require payment by the participant. Electing FSA under COBRA gives terminated employees an opportunity to incur and submit expenses that exceed their contributions.

12-month coverage period. The plan documents can state that enrollment in the Healthcare FSA is irrevocable for a 12-month coverage period and that termination of employment is not a qualified status change for termination of the Healthcare FSA. The plan would have to apply this rule regardless of the account balance at the time of termination of employment (so this stipulation would apply to both over- and under-spent accounts). The employer could offer terminated employees the option of paying the remainder of the monthly

contributions as payroll deductions from their last paycheck but cannot require this payment method. This option could include post-employment collection of the monthly contribution.

Another way to reduce or control your risk is to include in the plan documents your plan's COBRA rights and the administrative rules that apply based on your plan type and plan design.

To learn more about FSA and COBRA plans, contact Mark McDill at BenefitHelp Solutions at 503-765-3579.



Accelerated contributions must be uniform for plan participants

During open enrollment, an employee elected to contribute \$5,000 to a calendar-year Dependent Care Assistance Program (DCAP) for the following year. She plans to go on maternity leave starting August 1, but by that time, she will have contributed only \$2,916 to her DCAP. She wants to accelerate the full amount of her contribution before going on leave — that is, she would like to deduct \$2,084 from her last preleave paycheck. She would then like to be reimbursed for the full \$5,000 of DCAP expenses that she has already incurred during the year. However, these alternative salary reductions are not allowed.

Under the 2007 proposed regulations, the interval for salary reduction contributions must be specified in the plan and must be uniform for all participants. Thus, it appears that a plan document may not permit such alternative salary reduction arrangements, nor should an employer and employee agree to accelerated salary reductions. In contrast, the regulations would not appear to prohibit arrangements involving unequal salary reduction amounts that apply on a uniform basis — for example, a plan covering teachers could take salary reductions for 12 months of benefits over a nine-month period for all teachers.

STEVE SCHMIDT (continued from pg. 1)

clients. You can contact him at schmids@odscompanies.com or 503-765-3455.

BenefitHelp Solutions' former Managing Director, Margaret Thornburg, has accepted a leadership role at ODS Health Plan as Director of Medical and Dental Claims. Under Margaret's leadership during the last two years, BenefitHelp Solutions has become one of the strongest benefit administration outsourcing vendors in the region. Please join us in congratulating Margaret.