

Benefit Insights

Genetic Nondiscrimination Proposal Would Affect Employment, Insurance Practices

The forward march of science frequently brings with it advances in medicine. Over the years, new vaccines, therapies and medications have controlled—or even eliminated—diseases that once threatened populations.

The recent mapping of the DNA sequence of the human genetic code is the latest development that holds promise for improving human health. Knowledge of the human DNA sequence can lead to better ways to diagnose, prevent and treat diseases. For example, a thorough understanding of the human DNA sequence has made it possible to screen for the presence of genes that are associated with particular diseases. Individuals with a family history of cancer, for example, could undergo screening to determine if they possess the associated gene, and use the results to help them in making their health care and lifestyle decisions.

The idea that information about an individual's current and possible future health that can be learned through genetic screening has raised concerns that this knowledge could be used in a discriminatory manner. For the past several years, Congress has considered legislative proposals designed to address this concern. Recently, one of these proposals passed the Senate. S. 1053, The Genetic Information Nondiscrimination Act, passed the Senate on October 14, 2003, by a vote of 95-0. The Bush Administration has said that it supports the measure.

The sponsor of the Senate measure, Sen. Olympia Snowe (R-Maine), has been quoted as saying that statistics show many individuals with a family history of a specific disease are reluctant to be screened for it, for fear they will lose their jobs or insurance based on the results. Essentially, the provisions of S. 1053 restrain employers and insurers from using individual or family genetic information in making employment or insurance decisions.

S. 1053 applies to all health insurance markets, including employer-sponsored group plans and group and individual health insurance issuers. If enacted, insurers would be barred from using

genetic information to deny coverage or set rates, from collecting or using genetic information for underwriting purposes, and from requesting or requiring individuals to take genetic tests.

Employers would be prohibited from using genetic information in making employment decisions, including hiring, firing, compensation and promotions. Employers also would be prohibited from collecting genetic information on employees, except in connection with certain specified reasons, such as monitoring the effects of hazardous materials in the workplace.

This legislation defines genetic information as the genetic tests of an individual or family member or the occurrence of a disease or disorder in family members. Genetic information also includes a request for or a receipt of genetic services by an individual or family member. Such a broad definition, it is thought, will encourage individuals with a family history of a specific disease to take advantage of genetic advances and be screened, rather than fear that screening results might be used against them.

A basic question surrounding S. 1053 is whether it is necessary, in light of existing law and regulation. For example, the Health Insurance Portability and Accountability Act (HIPAA) contains provisions against the use or disclosure of individually identifiable health information, including genetic information. The Americans with Disabilities Act (ADA) also provides protections for individuals against discrimination. Since any new legislative enactment comes with the related cost of ensuring compliance, opponents of S. 1053 argue that measure will add costly regulatory burdens that are unnecessary, given the protections in existing law.

Though passed by the Senate, S. 1053 has yet to be acted on by the House of Representatives. With the upcoming campaign season and questioning by opponents of the proposal's benefits versus its cost, chances for passage remain uncertain.

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Tobias Insurance Group, Inc.
9247 North Meridian Street, Suite 300
P.O. Box 90380
Indianapolis, IN 46290

Phone: (317) 844-7759
Fax: (317) 844-9910
Website: <http://www.tobias.com>



Disability Insurance and the Buy-Sell Agreement

If you own a small business, you've probably heard the term "buy-sell agreement." In fact, your attorney or accountant has probably mentioned the need for one a time or two.

Buy-sell agreements do several things. Their three main functions are to ensure an orderly transfer of your business when you die; set a value on the business for transfer and tax purposes; and plan the succession of an owner who is disabled and can't contribute to the bottom line.

Let's look at the disability provisions that should go in a buy-sell agreement...

- Income replacement
- Overhead expense payments
- Ownership interest

There are, correspondingly, three types of disability insurance that should be considered for inclusion in the terms of your buy-sell agreement.

Disability Income Insurance (DI). This is insurance that provides a monthly benefit to replace income paid to a disabled person (owner or employee). The premium tends to run about 1-2% of the person's annual salary for salary replacement through age 65, and the benefit is usually paid tax-free provided the recipient paid premiums out of his/her pocket. If the company pays the premium, the cost will be higher but the premium is tax-deductible for the company and the benefit is taxable to the recipient. It is very expensive to continue to simply pay the salary of someone who can't contribute, even if that someone is the owner, so DI is a low-cost way to protect an asset—the owner's income—while

protecting the company's cash flow. There are many features available to enhance policy benefits—we can help you decide what's right for you.

Business or Professional Overhead Expense Insurance (BOE/POE). This is an important coverage for a business with a sole owner. DI insurance replaces income, but does not pay the day-to-day costs of continuing to run a business when the owner is disabled. Rent and utilities and salaries don't just go away. If there is a chance the owner will return to the business, this insurance will increase the likelihood there will be a business to come back to. If disability triggers sell provisions of a buy-sell agreement, these payments will ensure there is a viable entity to sell.

Disability Buy-Out Insurance (DBO). If the disabled owner is unable to return to work, DBO insurance will enable the business or the buyer under a buy-sell agreement to purchase the disabled person's interest in the business at a pre-determined monthly, annual, or lump sum payment level. DBO insurance does not preempt DI insurance, so the disabled owner gets a fair price for his or her business interest and continues to receive the agreed-upon DI payments.

It's easy to skip these provisions in buy-sell agreements—in fact, many attorneys only look at the buy-sell agreement as a way to maintain liquidity and pass the business interest at the death of an owner. Yet, you are two to four times more likely to become disabled while working than to die (depending on what industry statistics you use and how old you are now). Doesn't it make sense to protect your ability to earn a living? After all, that's probably your most valuable asset.

Non-Prescription Medications Are Now Eligible for FSA Reimbursement

In September 2003, the IRS announced that employees who participate in health care flexible spending accounts (FSAs) at work could use pretax dollars to buy nonprescription (over-the-counter) drugs, retroactive to the beginning of the plan year. Examples of such drugs include cold remedies, allergy medications, aspirin, and antacids (although items "merely beneficial to the employee's health," like dietary supplements and vitamins, aren't included).

The impetus behind the ruling is the growing number of drugs that are becoming available without a doctor's prescription. The IRS noted that consumers often end up paying more for such non-prescription drugs because even if they are less expensive than their prescription counterparts, consumers must pay the full price for a non-prescription drug instead of an insurance co-payment for a prescription drug. Employees now may be able to purchase a less expensive OTC medication instead of a brand name Rx, and use their pre-tax funds to pay



for the purchase.

The IRS ruling provides individuals with greater flexibility in using their FSA dollars, particularly at the end of the plan year, when all unused dollars are forfeited. But there's a catch--the employer's plan must allow it. Some plans expressly exclude non-prescription drugs, so these plans will need to be amended before an employee can use his or her pretax FSA dollars for such purchases.

This ruling also makes clear that the list of eligible expenses for reimbursement by health care FSAs is broader than the list of eligible expenses for the itemized deduction for medical expenses-- the cost of non-prescription drugs still can't be included for this deduction.

Now, with many over-the-counter medications being reimbursable, a larger segment of employees is expected to find FSAs of greater use. For more information on eligible expenses for health care FSAs, see IRS Publication 502.

Employers Should Beware of Health Insurance Scams

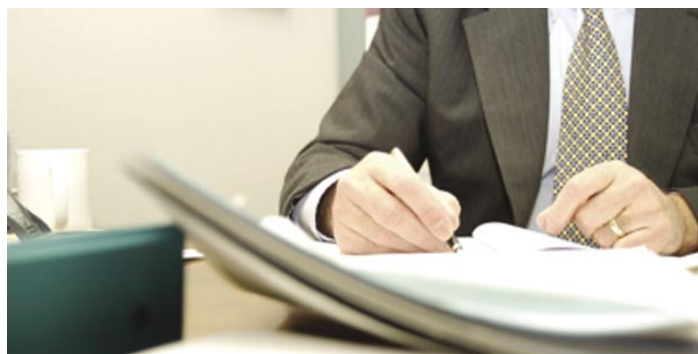
Some 15,000 employers fell victim to health insurance scams between 2000 and 2002, according to a March 2004 report from the General Accounting Office (GAO). Companies offering the policies collect premiums and may even pay some claims before simply disappearing, leaving employees who believe they have health insurance with uncovered medical bills and employers to deal with the wreckage in their employees' lives.



"Tens of thousands of employers and hundreds of thousands of individuals have paid premiums for essentially nonexistent coverage," said Kathryn G. Allen, Director of Health Insurance Studies at the GAO. The GAO investigation found at least 144 companies that were marketing health coverage between 2000 and 2002 they were not authorized to sell. Investigators found \$252 million in unpaid claims on some 200,000 phony policies. Employers and individuals in every state have been victims.

With health insurance premiums continuing to climb nationwide, federal investigators have witnessed significant increases in these health insurance scams by unlicensed companies. In many cases, policyholders discover that they have been defrauded only after they incur large medical bills, which their health plans will not pay.

Many bogus insurers falsely claim that they are exempt from state regulation. By the time unsuspecting customers realize the truth, the promoters of these bogus policies have often changed their names and moved to other states.



Many of the bogus insurers directed their marketing to small businesses, self-employed people and uninsured workers in the construction, food service, and other industries, the GAO report said. More than one-fourth of the phony health plans were offered through associations of employers or individuals.

The number of bogus insurance companies identified by federal and state officials nearly doubled, to 60 in 2002, from 31 in 2000. The GAO found five or more bogus insurers in every state. The number ranged from 5 in Delaware and Vermont to 31 in Texas. Seven states had 25 or more bogus entities selling health benefits. They were Texas with 31 companies; Florida, with 30 companies; Illinois and North Carolina, with 29 each; New Jersey, with 28; Alabama, with 27; and Georgia, with 25.

Insurance regulators in 30 states said they had issued 108 cease-and-desist orders to stop the marketing of health coverage by 41 of the 144 companies improperly marketing the insurance. The Department of Labor obtained court orders against three companies that had left \$39 million in unpaid claims, the report said.

The GAO said that prosecuting the phony companies was often difficult because they kept poor records, hid their assets, and refused to cooperate with investigators. Some were nearing bankruptcy when they were detected.

Typically, the scam artists offer lower rates than legitimate companies with the goal of getting premiums from as many subscribers as fast as possible so they can walk away with millions in premium dollars. They claim to offer comprehensive coverage at premiums much lower than those charged by state-licensed insurers. One state insurance commissioner said the plans can "seem like a dream to many employers and individuals. Unfortunately, the dream quickly becomes a nightmare."

One victim who testified at a recent Congressional hearing said she had been left with \$500,000 in medical bills after an unlicensed health plan refused to pay for a liver transplant her husband received. A federal court has acted to shut down the sponsor of that plan, which was based in Nevada and sold coverage to more than 22,000 people.

To avoid becoming the victim of a bogus health insurer, be suspicious of any offer of health insurance that is significantly lower in price than policies offered by other legitimate insurers. Be suspicious of any insurance that is marketed as being exempt from state regulation. Call your state insurance commissioner to verify this claim.

These scam artists prey on the desire of employers and individuals to find more affordable health insurance coverage. If an offer sounds too good to be true, no matter how smooth and convincing the sales pitch, it probably is just that.

Debit Card Technology for FSAs and HRAs Just Got More Attractive

Employers will no longer be required to file a Form 1099 for medical care payments made under flexible spending accounts (FSAs) or health reimbursement arrangements (HRAs), under a provision of the Medicare Prescription Drug and Modernization Act (Medicare Act). This exception to the general 1099 reporting requirement makes debit card technology for FSAs and HRAs more attractive.

Generally, federal tax law requires that any person who makes specified payments of \$600 or more in the course of a trade or business must provide an information report to the IRS (Form 1099) and furnish the recipient of the payments with a copy. Payments for medical or health care services are covered by this federal tax provision.

Under the way FSAs and HRAs were traditionally administered, the 1099 requirement was not an issue. Participants paid for health expenses out-of-pocket, and then filed a claim for reimbursement with the employer or FSA/HRA administrator. The provider of medical services was not paid directly. However, in 2003, the IRS issued Rev. Rul. 2003-43, which approved electronic debit cards for FSAs and HRAs. This technology stores the FSA/HRA participant's available account balance on a debit-type card. The participant can use the card for co-payments, prescriptions, or other health care expenses, rather than paying for these expenses out-of-pocket and filing a claim for reimbursement. The convenience of debit cards

and elimination of out-of-pocket payments and claims filing is thought to encourage participation in and use of FSAs and HRAs.

However, Rev. Rul. 2003-43 specified that payments made to medical service providers through the use of debit, credit, or stored value cards were reportable on Form 1099-MISC. So, while these types of cards were easy for participants to use, the Form 1099 requirement added an administrative task for employers.

With the Medicare Act eliminating the 1099 reporting requirement, debit card technology should become more attractive to employers. (The change made by the Medicare Act applies to any payments made for medical care from FSAs or HRAs, not just those made using a debit card.)

The elimination of the 1099 requirement applies to FSA/HRA payments made after December 31, 2002. Thus, employers that already had implemented debit card technology for their FSAs/HRAs for the 2003 plan year are not required to complete Form 1099 reporting for those payments.

If you have been considering adding a debit card to your FSA or HRA, elimination of the 1099 reporting requirement is another factor weighing in favor of doing so. Increased participation in the plan (if voluntary, like the FSA) and better appreciation of your benefits offerings are likely results. Now, you can achieve these without the added paperwork of the 1099.

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INSURANCE GROUP, INC.

9247 North Meridian Street, Suite 300
P.O. Box 90380
Indianapolis, IN 46290

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