

Benefit Insights

With Consolidated Regulations Package, Now Is the Time to Check Cafeteria Plans for Compliance

Over the past 20-plus years, the Internal Revenue Service (IRS) has issued, in dribs and drabs, regulations, notices and other guidance on Sec. 125 cafeteria plans. In proposed regulations effective in general for 2009 plan years, the IRS now has consolidated its cafeteria plan guidance, along with clarifying and elaborating on various cafeteria plan issues. The regulations are lengthy—124 pages—so in this article we highlight some of the points that are most significant for employers that offer some type of cafeteria plan.

Keep in mind that the term “cafeteria plan” can encompass arrangements as simple as premium-only plans or flexible spending accounts (FSAs), those as elaborate as choice-making plans with employer credits and a wide selection of benefits, or something in between. These requirements for cafeteria plans apply to any of these types of arrangements.

- The cafeteria plan must be in writing, and the plan must be operated in accordance with the written plan terms. The regulations specify all that must be included in the written plan document. Remember that the requirement that the plan be in writing applies to all types of cafeteria plans, even premium-only plans.
- All participants in a cafeteria plan must be employees, which the regulations define to include common-law employees, leased employees and full-time insurance salespeople. Former employees, including laid-off employees and retirees, may participate, but the plan cannot be maintained predominantly for them. Spouses and dependents may receive benefits under the cafeteria plan, but cannot “participate” in the plan. Self-employed individuals, including sole proprietors, partners, directors and 2% shareholders in Subchapter S corporations, are not considered

employees and thus may not participate in a cafeteria plan, but they could sponsor a plan for employees.

- The regulations specify the kinds of benefits that can be included in a cafeteria plan. Of note—
 - If group-term life insurance is offered, employers must use Table I as the exclusive method of computing the cost of such coverage in excess of \$50,000 (which is includible in an employee’s income). This provision is effective immediately.
 - Individual health insurance premiums, as well as an employee’s or former employee’s COBRA premiums, can be paid through a cafeteria plan (but not through an FSA).
 - Among benefits defined as nonqualified (and a plan that offers nonqualified benefits is not considered a cafeteria plan) are contributions to Archer medical savings accounts, contributions to health reimbursement arrangements, group term life insurance for spouses or dependent children, and elective deferrals to Sec. 403(b) plans.
- A change in plan year, or a short plan year (less than 12 months), is only permitted for a valid business purpose.
- Though a cafeteria plan may not provide for deferred compensation, the regulations specify certain types of plan features that are not considered deferred compensation, such as a long-term disability policy paying benefits for more than one year, certain two-year lock-in vision and dental policies, and certain advance payments for orthodontia.
- Though cafeteria plan elections generally are irrevocable (other than for changes in status or life events), the regula-

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Welcome to Our Newsletter!

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You might have heard that pharmacies in retail/grocery stores such as Wal-Mart and Kroger offer less expensive prescription drugs than if you went elsewhere. These discounts could turn into great savings for your plan participants. Wal-Mart has recently expanded its list of \$4 generic prescription drugs. Target also sells many generic drugs for \$4. Many Kroger pharmacies will match the \$4 generic drug pricing, as long as the drug is on the Wal-Mart list. Meijer offers many leading antibiotics for free, regardless of insurance. You might want to share this information with your employees. Please contact a Tobias Benefits Agent or Danielle in Customer Service for the internet link to the listing by pharmacy. Please call 317-844-7759 to discuss further.

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Employers Are Investing More in Improving Employee Health, But to Mixed Employee Response

Employers are beginning to view employee health and productivity as a critical business investment, and many are becoming more directly involved in managing the individual health of employees, according to a survey from the HR consulting firm Hewitt Associates. However, few employees agree that their employers have a role to play in helping them to stay healthy and many question their employers' motives in becoming involved in employee health management, another Hewitt survey reports.

The survey of employers found a "fundamental shift" in how companies are viewing health care. Though immediate cost containment remains a concern, 88% of employers (up from 63% last year) said they plan to invest in longer-term solutions aimed at improving employee health and productivity. Among these solutions—

- 85% plan to invest significant resources in long-term health and productivity initiatives;
- 67% plan to use health care data and measurements to drive their organization's health care strategy; and
- 63% plan to offer incentives to motivate sustained health care behavior change.

Though employers are taking a more activist role in employee health management, expect many employees to resist these efforts. While a majority of employees (74%) said that employers are responsible for helping employees to understand how to use their health plan, only 12% said their employers have a role to play in helping them understand how to stay healthy. This is despite virtually all employees (95%)

agreeing that taking care of their health today directly impacts what they will pay out-of-pocket for health care in the future.

That employers and employees are at odds on the issue of employee health management poses a challenge for employers that are looking beyond traditional cost management techniques like cost shifting to manage their company's health plan expenditures. Compounding this challenge is that employee behavior doesn't always pave the way for long-term good health and lower costs. Though 88% of employees claimed they engage in healthy behaviors, only 47% said they eat right and only 40% exercised regularly. Furthermore, cost concerns also resulted in employees sometimes not doing what was best for their health—because of cost concerns, 30% skipped going to the doctor, 27% didn't fill a prescription, and 19% stopped taking medication before a prescription ran out.

As far as employees' reaction to specific measures employers are taking, 70% supported lower health plan premiums for employees who lead healthy lifestyles, but only 46% agreed that a lower premium should be applied in exchange for completing a health risk appraisal. An even lower percentage, 36%, agreed that companies should require a health risk appraisal in order to obtain health care coverage.

Survey data such as this underscores the reality that implementing creative, long-term health care cost containment measures will be a challenge for employers. Yet such efforts need to be pursued, because motivating employees to consistently maintain healthy behaviors will undoubtedly prove to be critical for sustained health care cost management.

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tions permit employees to prospectively elect, revoke or change salary reduction elections for HSA contributions at any time during the plan year with respect to salary that has not become currently available at the time of the election. The regulations also permit automatic default elections for employees who fail to actively elect, and they permit new employees to make elections within 30 days of hire that are retroactive to the date of hire.

- Health FSAs may be established for limited purposes, such as an HSA-compatible limited-purpose health FSA or a post-deductible health FSA. Also, an employer can limit FSA enrollment to employees who participate in the health plan. A dependent care FSA may allow terminated employees to spend down their account through the end of the plan year. Employers can retain FSA forfeitures,

use them to defray administrative expenses, or allocate them to participants.

- The regulations provide guidance on cafeteria plan non-discrimination tests, define several key terms (including highly compensated individual, 5% shareholder, key employee and compensation), and specify that nondiscrimination testing must be performed on the last day of the plan year. They also create a nondiscrimination testing safe harbor for premium-only plans.

With this consolidated package of guidance for cafeteria plans, the IRS is likely to take enforcement more seriously. Now would be a good time to go through your cafeteria plan written document and administrative procedure and check for any compliance issues.

Increased Generics Usage Helps Slow Prescription Drug Spending Trend

According to pharmacy benefit manager Express Scripts, increased usage of generic drugs helped slow growth in prescription drug costs for 2007, resulting in an estimated \$5.2 billion in savings for benefit plan sponsors and their employees. In 2007, total spending on prescription drugs grew 4.7%, the slowest rate-of-growth ever reported by the company.



Data shows that average prescription costs increased just \$1.09 to \$54.34 in 2007, up from \$53.25 in 2006. Factors contributing to higher costs included a 2.5% increase in overall utilization and 7.4% increase in average brand name drug prices, while average generic drug prices decreased 3.1%.

Without the so called “generic effect,” the cost per prescription would have increased \$3.58 to \$56.83.

Generic purchasing power wielded its biggest impact on cholesterol drugs, the nation’s most-prescribed drug category. Both Pravachol(R) and Zocor(R) went generic in 2006, causing a significant shift in generic utilization of these drugs. Costs for cholesterol drugs overall fell 15.5% in 2007, averaging \$67.32 per prescription versus \$79.48 in 2006. Express Scripts reported that 48.9% of all prescriptions in 2007 for a cholesterol drug were for a generic, while 63.7% of all prescriptions filled were for a generic.

On a per-member-per-year basis, spending in 2007 increased from \$762.76 to \$798.76, including both plan costs and member co-payments. Had generic utilization remained constant, spending would have been \$32.53 higher for each of the nation’s 158.5 million commercially insured employees.

To determine drug trend, Express Scripts includes both member co-payments and plan sponsor costs to calculate total cost. The company also accounts for changes in utilization, the relative rates at which brands and generics are used, price inflation, units per prescription and changes in the mix of chemical entities and dosage forms used.

Research such as this clearly shows the cost savings potential that generic drugs can offer to an employer’s health plan. Co-payment differentials that make generics significantly more cost-effective for employees and communications that educate employees on generics’ safety, effectiveness and affordability can lead to increased generic usage and, ultimately, help in moderating health plan costs.

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“wellness program” that would be subject to the rules. For example, a “disease management program” for diabetes could be subject to the regulations for wellness programs



if it was part of a group health plan and offered a reward—such as a reduced health plan premium—to individuals who met an established health standard—such as participating in the program and succeeding in lowering their blood sugar level by a stated amount. In contrast, if employees could receive the reduced premium for enrolling in the program, attending educational sessions and following their doctor’s recommendation on diet and exercise—without having to meet a standard related to a health factor—there would be no HIPAA discrimination concerns.

For wellness programs subject to the rules, the bulletin goes through, point by point, the five criteria noted above to determine compliance.

Though the checklist is no substitute for program review by legal counsel or a benefits professional, it is a quick and easy way for you to assess whether such a consultation is in order. FAB 2008-02 can be accessed through the DOL’s Employee Benefits Security Administration’s Web site, at www.dol.gov/ebsa/regs/fab2008-2.html.

DOL Checklist Helps Determine Whether a Wellness Program Complies with HIPAA

Provisions of the Health Insurance Portability and Accountability Act (HIPAA) generally prohibit a group health plan from discriminating based on a health-related factor. However, HIPAA carves out an exception for certain wellness programs, allowing a plan to vary benefits—for example, charge a lower premium or reward employees in some other way for healthy behavior—for individuals who meet the pro-

grams standards. DOL regulations spell out the five criteria that a wellness program that varies benefits based on a health-related factor must meet in order to qualify for the HIPAA exception. For calendar year plans, these regulations became effective in 2008.

In an effort to assist employers in determining whether a wellness program they offer is subject to the regulations and, if it is, whether it complies, the DOL has issued a Field Assistance Bulletin (FAB 2008-02), which contains a flowchart-type checklist of questions that help lead employers to an answer.

In order not to violate HIPAA, the five requirements that a wellness program discriminating based on a health-related factor must meet are:

1. Any reward cannot exceed 20% of the health plan premium.
2. The program must be designed to promote health or prevent disease.
3. Employees must be able to qualify for the program at least once a year.
4. Alternatives to earning the reward must be available to

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