

BENEFIT

Plan Developments

A monthly report covering plan design and legislative changes

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529 Plans Becoming A More Attractive Benefit Offering

Due to the relative ease with which **529 college savings plans** can be added to benefit offerings, along with the added bonus of payroll deductions, more companies have been finding them to be attractive. However, employees have been slow to sign-up for 529 plans because of general confusion. All 50 states either offer, or are planning to offer, their own versions of 529 plans, many are open to non-residents, and each state plan has its own investment options. A study by Fidelity Investments in 2001 revealed that 66% of college savers were unaware of IRC Sec. 529 plans, and 84% of Americans did not realize that the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) included provisions that made 529 plans more attractive for savers.

IRC Sec. 529 plans were implemented by the Small Business Job Protection Act of 1996. Under the 1996 Act,

contributions made to a Sec. 529 plan were to be made in after-tax dollars, and earnings were to be tax deferred, while withdrawals were to be taxed at

the beneficiary's rate. With the passage of EGTRRA, earnings distributed from a Sec. 529 plan after Dec. 31, 2001, are no longer subject to federal income tax, provided funds are used for higher education expenses including tuition, fees, books, room, board, and supplies.

In addition, the 2001 legislation liberalized rollover rules and beneficiary eligibility for Sec. 529 plans. A participant can now roll over funds from one plan to another once every 12 months, thus allowing for consolidation of different Sec. 529 plans, and has increased flexibility to change from one Sec. 529 plan to another. In addition, an owner of a Sec. 529 plan can also change beneficiaries as often as desired, and even name first cousins as beneficiaries.

Contributions made to a 529 plan are considered completed gifts for the purposes of the federal gift tax laws, even though the contributor may reclaim the

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Services to Value, People to Trust

Plans can tailor privacy procedures to fit their particular needs.

funds or change the beneficiary at any time. A complete withdrawal of the funds, however, could create a taxable event and trigger a 10% additional penalty. Under the current provisions, an individual can contribute up to \$50,000 (married couples, up to \$100,000) to a Sec. 529 plan in one year per beneficiary without using any unified credit against federal gift and estate tax, and without incurring federal gift tax.

According to some studies, the market for 529 plans is expected to grow by more than 8% over the next few years, to where it could reach \$51 billion by 2006. Many money management professionals believe that 529 plans have the potential to become as popular a savings vehicle for college as 401(k) plans have been for retirement.

Patient Privacy Law Takes Effect

April 14, 2003

The first-ever federal regulation that gives patients widespread protection over the privacy of their medical records takes effect April 14, 2003. Smaller health plans, however, have until April 14, 2004 to comply. The regulation, created in conjunction with the Health Insurance Portability and Accountability Act (HIPAA), guarantees patients access to their medical records, as well as increased control over how their health information is used and disclosed.

The U.S. Dept. of Health and Human Services (HHS) issued the regulation and it will be implemented and enforced by the Office for Civil Rights (OCR). With the aim of making adoption of the privacy regulation as easy as possible,

providers and plans are allowed to tailor privacy procedures to fit their particular size and needs.

Under the privacy rule:

Health care providers or health plans must give patients information about their privacy rights. The information must be useful to patients in choosing a health plan, doctor, or other provider. Patients must acknowledge receipt of this information.

Carriers may—but are not required to—obtain general consents from covered individuals for the use of health information for treatment and payment operations.

Patients must give authorization before entities could use disclosure protection information in most “non-routine circumstances” such as the release of information to employers.

Health plans and other entities must obtain an individual’s authorization before sending them marketing materials. Furthermore, the regulation stipulates that covered entities cannot use business associate agreements to circumvent the marketing prohibition.

Patients will have access to their medical records and can request that errors be corrected. They may also request to know how their records may have been used or disclosed.

HHS stated the privacy regulation is designed to improve upon the protections of existing state laws but not replace other stronger state or federal laws. Furthermore, the privacy standards for covered entities apply whether its patients are privately insured, uninsured, or covered under public programs such as Medicare or Medicaid.

The federal government has estimated that the expense of the privacy regulation to the private sector of the health industry alone will be more than \$20 billion.

IRS Relieves Employers From Filing Schedule F

Employers who maintain specific fringe benefit plans are relieved from the requirement that they file annual information returns (Schedule F) with their completed Form 5500. In issuing Notice 2002-24, the Internal Revenue Service announced the change, and said it was considering if Schedule F and Form 5500 are the appropriate methods of reporting information required by IRC Section 6039D. Until it provides further guidance, the IRS said the relief will be in effect.

The notice applies to stand-alone **Section 125 cafeteria plans**, **Section 127 education assistance programs**, and **Section 137 adoption assistance programs**.

In general, the IRS noted that relief from filing Schedule F with Form 5500 must not be confused with a blanket relief from filing Form 5500. Although Form 5500 no longer must be filed with respect to the three specific benefit plans mentioned, if they stand alone, plans that otherwise fall within ERISA (Employee Retirement Income Security Act of 1974) or other regulatory guidelines for filing a Form 5500 must still do so.

Although unclear from Notice 2002-24, it's possible that small group plans may be exempt from filing a Form 5500 even if they establish fringe benefit plans under Sections 125, 127, or 137. The IRS is expected to issue further guidelines in this area.

Prior to Notice 2002-24, through Section 6039D of the Internal Revenue Code, the IRS required 125, 127, and 137 plans to file an information return with the IRS. The

filing was required through the IRS and not through ERISA because the latter does not consider these fringe benefits to be welfare benefit plans. Notice 2002-24 does not and cannot relieve employers from the requirement to file Form 5500 with respect to any welfare benefit plan as defined by ERISA.

Three-Year Project Will Test PPOs For Medicare Retirees

The U.S. Department of Health and Human Services has announced a three-year demonstration project that will offer Preferred Provider Organizations (PPOs) to Medicare-eligible retirees in 23 states. The project was launched this month.

Historically, under the Medicare+Choice project, Health Maintenance Organizations (HMOs) have been the only alternative to Medicare's traditional indemnity programs. Like the Medicare HMOs, the Medicare PPOs could help employers control retiree health care costs, but the savings generated by the PPOs will depend largely on how much Congress is willing to inject into the program.

"We want seniors to have more and better Medicare options, including the kind of PPO plans that are the preferred choice of millions of Americans under 65 but are virtually non-existent in Medicare today," Health and Human Services Secretary Tommy G. Thompson said. "Demonstrations like this one will move us closer to that goal, while we continue to work with Congress to strengthen and modernize Medicare for all Medicare beneficiaries."

PPOs
could help
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Critical Illness Insurance Is Growing In Popularity

Critical illness insurance is growing in popularity as a payroll deduction benefit, according to statistics gathered by the Society for Human Resource Management (SHRM, 2002). According to SHRM, critical illness insurance was being offered by 32% of employers in 2001, as opposed to 26% the previous year. Much of the growing popularity of this product is linked to advances in medical technology, which have dramatically improved survival rates of those stricken with what were once virtually fatal diseases.

A critical illness plan can be crucial for employees of average income who may be living from paycheck to paycheck. The insurance fills financial gaps not covered by traditional health, disability, and accident insurance. Employees diagnosed with a qualifying illness—such as cancer, the need for an organ transplant, or a heart attack—typically receive a lump sum pay-

ment to help pay for various expenses. As a result, a critical illness plan can help retain and attract employees.

In general, an employer may deduct the amount of premiums paid for critical illness insurance as a business expense—as long as it constitutes reasonable compensation for services rendered. If coverage is provided only to owner-employees or shareholders or relatives of shareholders, the IRS may view the coverage as a form of dividend. As a result, premium payments would not likely be a deductible business expense. If the critical illness coverage is provided as an “accident or health plan” for employees, the cost would not generally be taxable to employees.

Insurance company studies show that the indirect costs of a critical illness can greatly outweigh the direct medical costs by a two-to-one factor. Indirect costs include rehabilitation, home health care, loss of income, and childcare. Further evidence of this fact is provided by the American Cancer Society (2002) which has estimated that 66% of the cost of cancer treatment is not covered by traditional insurance.

Critical care insurance fills the gaps not covered by traditional policies.

FAST FACTS

Statistical updates during 2002 from the American Heart Association and the American Cancer Society point to the fact that 75% of healthy people over age 40 will become critically ill at some point in their lives.

The Bad News/Good News:

- Americans suffer a coronary event every 29 seconds. . .12.4 million people alive today have suffered heart attacks, angina pectoris (chest pains) or both.
- Someone in the U.S. has a stroke an average of every 53 seconds. . . 4.5 million stroke survivors are alive today.
- One in two men and one in three women develop some form of cancer in their lives. . .8.9 million people alive today have had cancer.