

BENEFIT

Plan Developments



A monthly report covering plan design and legislative changes

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Bill Proposes Tax Deduction For LTC Premiums

Legislation with bipartisan support has been introduced calling for an above-the-line deduction for the cost of long-term care (LTC) insurance premiums, along with a \$3,000 tax credit for qualified individuals and their caregivers for long-term care expenses. In addition, the legislation calls for inclusion of long-term care coverage in employer cafeteria plans and within flexible spending accounts (FSAs).

The legislation, known as the *Ronald Reagan Alzheimer's Breakthrough Act of 2004*, was introduced by Reps. Nancy Johnson, R-CT and Earl Pomeroy, D-ND. Similar legislation has been proposed in the past but was never adopted. Supporters of the new act believe the recent death of President Ronald Reagan—who suffered from Alzheimer's disease—will increase its chances of passage.

Americans for Long-Term Care Security (ALTCS), a 32-member bipartisan organization based in

Washington, D.C., praised the introduction of the legislation. ALTCS has stated that more than half the U.S. population will require some type of long-term care during

their lives, and that more than six million elderly Americans currently need assistance from family or friends in order to live at home.

"We view this bill as having short-term and long-term value," said Janet Stokes Trautwein, vice president of government affairs for the National Association of Health Underwriters and a member of the ALTCS board of directors. "It will immediately present millions of American families with important choices including long-term care insurance as compared to self-financing or spending down assets to qualify for public programs. In the future, it will relieve fiscal pressure on state and federal programs, such as Medicaid, which today represents 57% of all spending on all long-term care, and estimates show that spending on long-term care could double by 2025."

Another member of the ALTCS board, Diane Boyle, managing director of the Association of Health

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Suspected abuse allows FMLA recertification.

Insurance Advisors (AHIA), said: “Studies have shown that long-term care is the largest unfunded liability confronting the boomer generation. We are less than ten years from when the first wave of boomers will turn 65, so we must be prepared to move this kind of long-term care legislation forward.”

Conditions For Recertification Under FMLA

The Family Medical Leave Act (FMLA) allows an employer to request recertification from an employee every 30 days for pregnancy or for chronic or permanent/long-term conditions. However, there are other circumstances under which recertification would be appropriate, according to an opinion letter issued by the Wage and Hour Division of the U.S. Dept. of Labor (DOL).

According to the opinion letter dated May 25, 2004, the DOL said an employer may request an employee to recertify the reason for using the FMLA if, “the employer receives information which casts doubt upon the continuing validity of the certification.” As an example, the DOL pointed to recurring periods of Friday/Monday absences used in conjunction with migraine headaches.

“If a medical certification indicated the need for intermittent leave for two or three days a month due to migraine headaches, and the employee took such leave every Monday or Friday, a recertification under these circumstances could be justified,” the DOL letter stated.

Employers who have observed such a pattern of potential abuse may indirectly ask the employee’s health care provider, as part of the certification and recertification process, “if this pattern of absence is consistent with the employee’s serious health condition.”

The DOL explains, “An employer’s

direct contact with the employee’s health care provider is prohibited, but...this question could be added to the medical certification form given to the employee for completion by the health care provider.” However, the opinion also noted that Regulation 825.307(a) permits a health care professional representing the employer to contact the employee’s health care provider for purposes of clarifying the information in the medical certification—if the employee gives permission.

CDHC Plans Destined To Become Widely Adopted

Consumer-driven health care (CDHC) plans, also known as defined contribution health plans, are coming to be seen “as an inevitable paradigm shift in health care” and are destined to become the next dominant form of health care insurance, according to a report issued by researchers at the University of Pennsylvania’s Wharton School and consultants at Booz Allen Hamilton.

In issuing their report, “Consumer Take Charge: Defined-Contribution Health Plans,” the researchers and consultants said that CDHC plans will never completely replace managed care institutions, “but they are another option that could have as significant an impact on the operating principles and direction of the health care sector as HMOs [health maintenance organizations] and PPOs [preferred provider organizations]” when they were introduced in the 1980s and 1990s.

Although the report said precise figures on the adoption of CDHC plans were difficult to determine, various estimates suggest they “now account for about 2% of all health care coverage in the United States.” That percentage translates into 300,000 to 400,000 people, or less than 1% of all company-insured employees, the report stated. Looking

ahead, however, the report said CDHC plans “will be much more common.”

Sean Nicholson, a professor of health care at Wharton, said rising health care costs are making companies pay closer attention to defined contribution plans. “At some point employers become infuriated with another 12% to 15% increase in annual premiums. They said, ‘We’ve got to try some new way to get costs down.’” Given the fact that no plan can keep medical costs growing at less than the rate of inflation, Nicholson said that “good plans” will be defined as those that allow premiums to increase at 6% to 8% a year.

Gary Ahlquist, a senior vice president with Booz Allen, noted that CDHC plans exist because they address an “incomplete agenda” left by 20 years of experimentation and failure with managed care. Another reason: companies have remained paternalistic toward their employees. “Businesses have gotten away from that paternalistic approach in the retirement area and now they’re moving away from it in the health insurance area,” Ahlquist said. “In the health care surveys we’ve done, employees tell us more and more that they want choices.”

HSAs Given Boost By IRS, Treasury Notice

Taxpayers prevented from establishing health savings accounts (HSAs) because they reside in states where their health insurance plans fail to meet the federal requirements for a high deductible may find temporary relief in Notice 2004-43 issued by the Internal Revenue Service (IRS) and the U.S. Treasury Department. The Notice allows such individuals to contribute to HSAs until Dec. 31, 2005—giving states time to modify their laws to conform to the high deductible requirements.

The IRS noted that some states did not have time to modify their laws to specify the need for high deductibles. The transition period is expected to allow them to have time for reform, allowing “otherwise eligible” individuals to contribute to an HSA.

According to the Employers Council on Flexible Compensation, the Notice “will allow HSAs to flourish and give an incentive for legislatures and insurance commissions to make changes” by the deadline. The transition relief period will not apply to state mandates that were not in effect on Jan. 1, 2004.

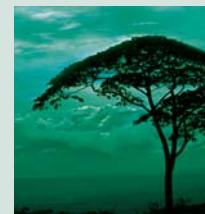
Further information regarding the notice is available from Shoshanna Tanner of the Office of Division Counsel/Associate Chief Counsel at 202-622-6080.

“Pharma” Industry Needs To Address Pricing Disparities

The pharmaceutical industry must take the lead in addressing the disparity in drug prices between the U.S. and other developed nations, or face the potential of government price controls and an increased level of drug imports, according to “Progressions: Global Pharmaceutical Report 2004.”

The report, issued by Ernst & Young, noted, “recent expansion of the U.S. market under the Medicare Modernization Act is likely to accelerate pricing pressures throughout the industry globally.”

Rather than oppose price control and reimportation at the risk of consumer backlash, the report challenged the U.S. pharmaceutical industry “to take the lead in a fresh two-part approach, one that is coordinated and future oriented. First, it must address drug prices and geographic price discrepancies. Second, the industry must communicate more effectively with all stakeholders to reestablish its credibility in the health care arena.”



Some states did not have time to modify laws affecting HSAs.

Blake Devitt, senior pharmaceutical practice leader for Ernst & Young, noted that government price controls would result in a substantial setback for industry profit margins as well as potential innovations.

A report issued this year by Alan Sager, Ph.D., and Deborah Socolar, M.P.H., of the Boston University School of Public Health, provided a financial overview of the rising cost of drugs in the U.S. The report noted that spending on prescription drugs in the U.S. will approach \$250 billion in 2004. "It has doubled every five years since 1994, rising more than twice as fast as the rest of health spending during (the) decade from 1994 to 2004. During these years, prescription drug spending has grown 4.5 times as fast as the economy as a whole."

Kathy Smith, Ernst & Young's new pharmaceutical practice leader, questioned if pharmaceutical company executives are doing enough to emphasize their own risk management and compliance efforts. "For most pharma companies, where innovation, manufacturing, and commercialization are natural points of focus, fostering a culture of risk management and compliance to the formula can only make the industry stronger. Furthermore, a strong culture of compliance goes a long way towards strengthening the public's trust in the industry."

Health Waiver Results In Reduced Coverage

Section 420 of the Internal Revenue Code allows an employer to transfer surplus pension assets to a separate account to pay for current retiree health benefits. When individuals entitled to

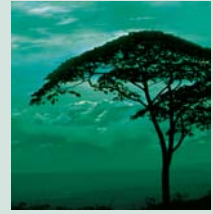
those health benefits accept their employer's offer to waive them in exchange for enhanced pension benefits, the employer has effectively reduced retiree health coverage and, as a result, could potentially violate Section 420, the Internal Revenue Service (IRS) has said in Revenue Ruling 2004-65.

To illustrate its point, the IRS provides a scenario in its ruling in which an employer maintains a defined benefit plan that contains a retiree health benefits account. From time to time, the scenario notes, the company makes qualified transfers of excess pension assets to fund applicable health benefits. One such theoretical transfer occurs on June 30, 2002. Then on July 1, 2004, the employer offers plan participants the opportunity to receive enhanced pension benefits in return for waiving their applicable health benefits.

At issue with the waiver, the IRS notes, is determining what constitutes "significantly reduced retiree health coverage during the cost maintenance period." According to IRS regulations, a significant reduction occurs if the employer-initiated reduction exceeds 10% during the cost maintenance period for any taxable year beginning on or after Jan. 1, 2002, or if the sum of the employer-initiated reduction percentage for that taxable year and all prior taxable years during the cost maintenance period exceeds 20%.

The IRS also provides guidance for calculating the reduction percentage: divide the number of people who waived their health benefits by the total number of people receiving benefits as of the day before the first day of the employer's tax year.

A copy of the IRS Ruling can be found at: <http://www.irs.gov/pub/irs-drop/rr-04-65.pdf>.



Health waivers can cause Section 420 violations.
