Employee Benefits Report

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How FSAs Help Employers and Employees Save Money

If your organization doesn't already offer healthcare flexible spending accounts, year-end is the perfect time to start. And if your organization does offer employees this valuable benefit, now is the time to re-educate them.

Flexible spending accounts or arrangements (FSAs) are accounts offered and administered by employers that allow employees to set aside, out of their paycheck, pretax dollars to pay for qualified medical expenses. These can include insurance premiums, vision or dental care, or any other medical expenses not covered by the employer's health plan. These accounts are allowed under Section 125 of the Internal Revenue Code and are also referred to as "cafeteria plans" or "125 plans."

Typically, employees must use FSA funds within the given benefit year or lose

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This Just In…

A rule requiring most private-sector employers to notify employees of their rights under the National Labor Relations Act (NLRA) by posting a notice , originally scheduled to take effect by November 14, now goes into effect on January 31, 2012. The change may allow the National Labor Relations Board (NLRB) to do more outreach to affected employers, but also gives two federal courts more time to consider challenges to the rule.

Copies of the notice will be available at no charge on the NLRB website and from NLRB regional offices. Failure to post the notice may be treated as an unfair labor practice under the National Labor Relations Act.

the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Employers may contribute to these accounts as well as employees. Currently, healthcare FSAs have no statutory contribution limit, although some employers limit contributions, usually somewhere between $2,000 and $3,000. Beginning on January 1, 2013, however, contributions will be capped at $2,500 per year.

FSA Advantages

Reducing their taxable income can save your employees an average of 30 percent on eligible medical expenses paid out of the FSA. And your organization can save approximately 7 to 10 percent for every dollar your employees place in an FSA on reduced employer state and FICA taxes. For many employers, these savings exceed the costs of administering employees' FSAs.

Despite these advantages, the National Compensation Survey by the Bureau of Labor Statistics found only 17 percent of all workers had access to an FSA. And of the employees with access, only 20 percent participate, according to a recent study by Harris Interactive for Aflac.

To get the most out of this low-cost benefit, you will need to invest time and energy in educating your employees. Some pointers:

- Educate your employees on the tax advantages of FSAs. Nearly everyone has out-of-pocket healthcare expenses. If you allow employees to deposit a maximum of $2,500 in an FSA, the tax savings translate into an average savings of approximately $750.
- Encourage employees to make a deferral decision. Automatic re-enrollment makes sense for a lot of benefits, but with an FSA, the default election is zero. If your employees do not make a deferral election by the deadline, they will forfeit this benefit for an entire year.
- Remind employees that FSAs are a "use it or lose it" proposition. Participants lose any funds remaining after the spending deadline, so encourage them to elect their deferral carefully. Under previous law, participants had to spend their FSA funds by the end of the company's benefit year, usually December 31. Any leftover account amounts were forfeited. In 2005, however, the Internal Revenue Service added a grace period, allowing plans to let participants to use their contributions to pay for healthcare expenses incurred as late as two and a half months after the end of the plan year. Employers do not have to allow a grace period, however.
- Send employees a reminder before year-end that they need to use their FSA balances. Provide a list of eligible expenses as a prompt. Suggestions for using FSA funds include scheduling routine preventive care appointments, such as vision and dental exams, stocking up on prescription drugs, getting flu and other vaccines, starting a smoking cessation program, and applying for reimbursement for mileage to eligible medical, dental and vision appointments. The IRS allowed 19 cents per mile driven for medical purposes from January 1 to June 30, 2011. From July 1 to December 31, mileage rates will be 23.5 cents per mile, due to higher gasoline costs.
- Remind employees that the Patient Protection Act changed the rules on using funds from an FSA or health reimbursement arrangement to pay for over-the-counter drugs. Employees can no longer use pre-tax dollars to pay for over-the-counter drugs, unless they have a doctor's prescription for them.
- Consider offering an FSA debit card. Without a debit card, employees must pay their healthcare expense out of pocket, fill out a form and wait for reimbursement. With a debit card linked to their flexible spending account, they can access funds immediately. Most vendors limit FSA debit card use to certified healthcare providers, such as pharmacies, clinics, etc. Even with a debit card, employees must keep their receipts to document that their expenses are FSA-eligible.

For information on FSAs, FSA debit cards and other administrative services that can simplify your benefits administration, please contact us.

The NLRA applies to employees in most private-sector workplaces, including manufacturing plants, retail centers, private universities, and health care facilities. Agricultural workers and domestic workers were excluded in the original law and are not covered. Also exempted are supervisors and independent contractors. The Act does not cover railway and airline employees, or federal, state or local government workers, with the exception of employees of the U.S. Postal Service.

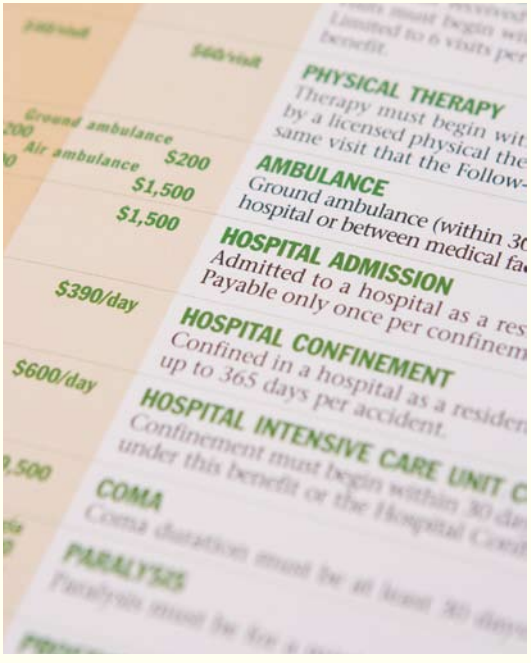
Prepare Your Health Plan for 2012

What changes are in store for employee healthcare benefits in 2012? Here are some facts that will help you better manage your program in the coming year.

Health insurance premiums: In 2011, average employer-sponsored family health plans cost $15,073—9 percent higher than 2010, according to a recent survey by the Kaiser Family Foundation and the Health Research and Educational Trust. Single coverage costs an average of $5,429, up 8 percent from 2010. Gary Claxon, director of Kaiser's Health Care Marketplace Project, attributed most of the cost increase to rising healthcare costs. Changes caused by the Patient Protection Act, which now allows children up to age 26 to remain on their parents' insurance and requires insurers to cover certain preventive services with no co-payment, accounted for about one percent of the increase.

Look for slightly better news in 2012. Preliminary findings from a Mercer survey indicate health benefit costs could increase an average of 5.4 percent, the smallest increase since 1997. Of course, this is still higher than the general rate of inflation and these are averages only. Premiums for your group could increase more or less, depending on group size, location and claims experience.

Mercer researchers attributed the smaller cost increase to lower utilization of health services. Several reasons could account for this: higher out-of-pocket costs discouraging employees from using healthcare; employees skipping non-urgent care due to less disposable income; employer wellness and disease management programs improving workers' health; or some combination of these factors.



Consulting firm Segal said in a recent news release, "Price inflation for services and supplies continues to be the biggest element of overall medical plan cost trends." To control medical costs, it recommends employers obtain deeper discounts from provider networks, invest in wellness and disease management, encourage healthier lifestyles, manage imaging/diagnostic technologies and implement value-based plan designs, among other steps.

Employee cost-sharing: Many employers will pass along most of the cost increases to their employees. According to Mercer, about one-third of survey respondents plan to raise deductibles or co-payments in 2012.

High-deductible health plans: To control their healthcare costs, employers are increasingly turning to high-deductible health plans linked to health savings accounts or health reimbursement arrangements. In 2011, 31 percent of workers with health insurance have high-deductible health plans. For 2012, a qualifying "high deductible health plan" must have an annual deductible of at least $1,200 for self-only coverage or $2,400 for family coverage — no change from calendar year 2011.

Reporting requirements: Employers must begin reporting the value of their health insurance coverage on employees' Form W-2 for tax year 2012. Employers are not required to report the cost of health coverage on any forms furnished to employees before January 2013. The requirement does not apply to employers filing fewer than 250 Forms W-2 for the previous calendar year. The IRS has clarified

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that reporting is for informational purposes only and employees will not be taxed on the value of their health benefits.

The Patient Protection Act also requires sponsors of most group health plans to provide a summary of benefits and coverage (SBC) to the plan's participants and beneficiaries. In the fall, the U.S. Departments of Labor, Treasury and Health and Human Services issued a proposed regulation that would make this requirement effective March 23, 2012. This means employers would not have to comply for 2012 calendar year plan open enrollments. However, if the proposed regulation is adopted, they will have to comply by mid-year HIPAA special enrollment dates.

SBCs must follow a specific format, with four pages and simplified language. Plan sponsors must provide SBCs with open enrollment materials, as well as to new hires and other new enrollees. Plan sponsors must also provide enrollees written notice of any plan changes at least 60 days before their effective date.

Healthcare reform: Employers remain apprehensive about the Patient Protection Act. In a May 2011 survey by Lockton, a consulting firm, 56 percent of employers said it would "significantly increase" their administrative responsibilities, while 26 percent said it would "slightly increase" those responsibilities.

As this issue went to press, the fate of the Act remained unclear. By fall of 2011, 26 states had sued to stop the law from taking effect. In August, a three-judge panel of the U.S. Court of Appeals in Atlanta ruled that the law's centerpiece, a requirement that individuals buy health insurance, was unconstitutional. In late September, the Department of Justice filed a cert petition asking the Supreme Court to review the 2-1 decision. This action makes it likely the U.S. Supreme Court will hear a case on healthcare reform in late 2011 or early 2012.

If you have any questions on managing your employee health benefits for 2012, please contact us.

FMLA Administration

The good news is employers are doing a better job of complying with the Family and Medical Leave Act (FMLA). Between 2001 and 2008, the number of complaints the U.S. Department of Labor received dropped by one-third, as did the number of violations found. And back wages paid by employers dropped by nearly half. Still, many employers find FMLA compliance confusing. To help your organization avoid the common pitfalls of FMLA compliance, a review of the basic provisions of the law and strategies for effective leave management follow.

FMLA Fast Facts

Which employers must comply? The FMLA applies to any employer that employs 50 or more workers in a 75-mile radius each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

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Which employees are eligible? Employees can take FMLA leave if they have worked for an FMLA-qualified employer for at least 12 months and have worked at least 1,250 hours over the previous 12 months.

How much leave can workers take? Eligible workers can take up to 12 weeks of leave per year for serious health conditions; to care for a family member (spouse, child or parent) with a serious health condition; or for childbirth, adoption or foster care. Workers can take leave consecutively or intermittently. Leave may run concurrently with workers' compensation, short-term disability and salary continuation.

What is "a serious health condition"? The FMLA defines this as incapacity or treatment that involves inpatient care (an overnight stay) in a medical care facility, as well as subsequent treatment related to inpatient care. It also includes any period of incapacity due to pregnancy, a chronic serious health condition or a health condition lasting more than three days that requires treatment by a health care provider. The FMLA also applies to absences to receive multiple treatments to address serious conditions.

What other responsibilities do employers have? The FMLA requires employers that provide health benefits to continue them during an employee's leave. Following the 12 weeks of unpaid leave, employers must reinstate the employee in the same job or an equivalent one. Employers that deny or restrict an employee's rights under FMLA may be liable for lost wages and benefits, as well as damages and legal fees. Keep in mind that medical privacy rules apply to FMLA, and safeguard any medical information.

The employer has the ultimate responsibility of designating FMLA-eligible leave as FMLA leave based upon information furnished by the employee. You may not wait to designate FMLA leave after the leave has been completed and the employee has returned to work, unless you are: (1) awaiting medical certification to confirm a serious health condition, (2) unaware that leave was for an FMLA reason, and later receive employee requests for additional leave or (3) unaware of the situation and the employee notifies the company of the FMLA leave within two days after returning to work.

Many states have their own family or medical leave laws. Check to make sure that your leave policies comply with state law, which may be more generous in certain areas, including: (1) employee hours requirement (1,000 vs. 1,250 hours), (2) the minimum number of employees required for the law to apply (15 vs. 50 workers) and (3) the definition of family member (to include in-laws).

What are employees' obligations? To qualify for FMLA leave, an employee must provide sufficient information to substantiate the need for leave. For medical leave, they do not have to have their health care provider supply a specific diagnosis, but merely certify the need for medical leave. Once an employee qualifies for FMLA leave, he or she does not have to provide advance notice if the leave is not foreseeable — for example, a migraine sufferer could leave work every time he gets a headache.

Should we outsource FMLA administration? Some employers use outside companies to manage their leave programs. Their reasons include avoiding potential litigation and fines, adding a layer of privacy regarding personal health information and reducing administrative burdens and the need for additional training.

Carefully evaluate an administrator's experience and qualifications. Outsourcing FMLA administration might not completely insulate your company from liability if there is a violation. However, you can require indemnification from vendors for negligence related to their administration of your company's FMLA program.

Whether you choose to outsource your FMLA administration or handle it in-house, you'll want a tracking process to ensure consistency and integration of FMLA with other benefits, including appropriate documentation and state-leave requirements. For more information on FMLA compliance, go to www.dol.gov/dol/topic/benefits-leave/fmla.htm ■

Long-Term Care Insurance: CLASS Shelved

As this issue went to press, it seemed likely that the CLASS government-managed long-term care insurance program would be tabled. In the fall, the Health and Human Services Department (HHS), which managed the program, reduced staffing at the CLASS office and pink-slipped its chief actuary.

Actuaries had long warned that adverse selection, a phenomenon where the sickest people are most likely to buy coverage, would cause the program to run out of funds unless it received taxpayer subsidies. Alternatively, the law could be changed to require workers to enroll, which would eliminate the adverse selection problem. However, a mandatory long-term care program would not likely appeal to voters.

Still, the lack of viable long-term care options could become a serious problem for the majority of baby boomers who do not have long-term care insurance. Private long-term care insurance remains the best alternative for most people to ensure they have the funds available to pay for long-term care services when needed. Employers can provide long-term care coverage on an employer-paid or completely employee-paid voluntary basis; for more information, please contact us. ■

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