

Employee Benefits Report



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This Just In

The IRS issued new proposed regulations for cafeteria plans in August.

The most significant changes include: 1) Participants must be able to choose from at least one taxable benefit (for example, cash) and at least one qualified benefit. 2) Plans must be written and operate in accordance with the plan document. 3) The self-employed, sole proprietors, partners, directors and those who own more than 2 percent of Subchapter S corporations cannot participate. Leased employees, full-time life insurance salespeople and former employees can. 4) A cafeteria plan (but not a health FSA) can now pay individual accident and health insurance premiums for employees. (Regulations are silent on payment of premiums for a spouse or dependent.) The regulations also permit plans to pay COBRA premiums for an employee. 5) Generally, if an employer or employers provide more than \$50,000 in group term life insurance to an employee, the cost of coverage amounts over \$50,000 is includible in the employee's gross income.

If approved, regulations will apply to plan years beginning on or after Jan. 1, 2009; however, some provisions (including those on group term life) became effective immediately.

Which Health Plan Applies?

When your employees are covered by more than one health plan, you'll want to know which plan is "primary" (insurance jargon for the one that pays claims first). Here's some guidance.

Let's consider two situations where dual – and dueling – coverage might occur. They both involve someone covered by two plans, but in one case, both plans are group plans, and in the second, one plan is group medical and the other is Medicare.

Situation One: Two group health plans

The rules that regulate the coordination of benefits and define the primary payer in a situation where two policies cover one per-

son are set by the state where the insured resides. The regulations vary from state to state.

The National Association of Insurance Commissioners (NAIC) has developed a model regulation for coordination of benefits. States have no obligation to use the NAIC model, but many do or have written regulations that closely resemble it.

According to NAIC, states that either have taken no action on the topic or have established regulations that differ significantly from the model are

Alaska, Florida, Hawaii, Maine, Maryland, Mississippi, New Mexico, Pennsylvania and Vermont. Washington, D.C., is also on that list.

Here are some nuggets from the NAIC model regulation:

★ If a policyholder is also covered as a dependent on a second policy, the policy he holds is primary and the policy that lists him as a dependent is secondary.

★ A dependent child of parents who both hold policies that cover the child and are living together is covered first by the pol-



IRS Updates 403(b) Regulations

It has been 43 years since the IRS has issued regulations governing the 403(b)s, the tax-sheltered retirement plans for most nonprofits and public schools. The new rules generally go into effect for plan years beginning after Dec. 31, 2008.

A 403(b) plan is a special type of retirement plan available only to 501(c)(3) nonprofits — generally hospitals, educational institutions, social welfare agencies and churches — along with public schools.

As with a 401(k) plan, a 403(b) plan lets employees defer some of their salary. The federal government and most state governments generally do not tax this deferred money until distributed. Funds in a 403(b) plan must be invested in an annuity contract issued by an insurance company, a custodial account invested solely in mutual funds or a church retirement income account.

In the past, 403(b) plans received less employer oversight than 401(k) plans. The new regulations make 403(b)s more like 401(k)s and conform IRS Section 403(b) to legislation passed and regulations issued since the plans were introduced in 1964. Although some changes are merely “housekeeping,” some will affect plan sponsors, including:

- ✦ Requiring that plans be written. The plan sponsor must identify its providers and the eligible investments. It must also outline information on eligibility requirements, contribution limits, hardship withdrawals, loan requirements and withdrawal procedures. Your written plan can include reference to other, relevant documents (such as insurance policies or contracts for custodial accounts).
- ✦ Elimination of so-called 90-24 exchanges. Until Sept. 24, 2007, employees who didn't like their employer's fund offerings could move the cash in their accounts to

other 403(b) providers at will. The new regulations will permit transfers for a section 403(b) contract only if: (1) it is a mere change of investment within the same plan, (2) another employer plan receives the exchange, or (3) it is a transfer to purchase permissive service credit (or a repayment to a defined benefit governmental plan). An exchange or transfer that does not meet these requirements would be subject to taxation.

- ✦ Elimination of the Notice 89-23 good faith reasonable standard for satisfying nondiscrimination requirements. A section 403(b) plan must comply with the nondiscrimination requirements for matching contributions in the same manner as a qualified plan.
- ✦ Allowing employers to exclude certain employees from making elective contributions. The current “universal availability rule” requires that if any employee can make elective deferrals, all employees can. The new regulations allow plans to exclude the following employees (with certain limitations): 1) those eligible to make deferred contributions under another section 403(b) plan or a section 457(b) eligible governmental plan, 2) those eligible to make a cash or deferred election under a section 401(k) plan of the employer, 3) non-resident aliens, 4) students performing services described in section 3121(b)(10) and 5) employees who normally work fewer than 20 hours per week, as set forth in the plan, subject to certain conditions.



The regulations also provide that:

- ✦ Employers must transfer contribution amounts for non-ERISA plans to providers within a reasonable period, such as transferring elective deferrals within 15 business days following the month in which these amounts would have been paid to the participant.
- ✦ Incidental life insurance, unless grandfathered, may not be part of a 403(b) plan.

Other changes might affect your organization's plan or employees; for more information, see [the IRS' 403\(b\) Web page](#) or contact us. Another site, created by former educators, provides information that 403(b) plan participants can use to make informed decisions at www.403bwise.com. ■



Legal Plans: What's the Verdict?

As of 2002, some 3 million Americans had enrolled in some type of voluntary legal service plan through their employer. In fact, the majority of people (57 percent) who voluntarily enroll in a legal service plan do so through their employer, according to a survey by the American Prepaid Legal Services Institute. Should you offer this benefit to your employees?

Some employee assistance programs (EAPs) provide specific (usually very limited) legal services, such as preparation of a simple will or one or two hours of free legal consultation with an approved attorney. If your company's EAP does not include legal services, offering employees some sort of legal plan can provide valuable peace of mind. Because the plans are voluntary, only employees who want them participate—and it costs you, the employer, nothing.

Before you offer a plan, though, here are a

few facts to consider.

1 There are two types of legal plans: an *access plan* and a *legal insurance plan*.

According to the American Prepaid Legal Services Institute's 2004 survey, most people enrolled in group legal service plans have an *access plan*, also known as a *prepaid legal plan*. This type of plan gives the participant access to an attorney from a pre-selected network, who will provide a specified number of hours of legal advice or consultation per year at no charge. Typical services might include a simple real estate contract review or simple will. If

the participant needs more in-depth services, he or she will pay the lawyer directly, but the plan usually guarantees a discount off the lawyer's usual hourly rates.

The access plan provides just that: access to an approved list of attorneys when your employees need simple legal advice, and the security of knowing that they have someone available to help them through minor legal problems or concerns.

The *legal insurance plan* has several differences from the access plan. A legal insurance plan is an insurance contract that works like an HMO, where the participant buys an insurance policy, pays monthly premiums and uses a "preferred provider" for services. And like most HMOs, as long as the service you require is covered and you use a network provider, you do not have to fill out claim forms and wait for reimbursement. If you use an out-of-network lawyer, your service will be reimbursed up to a certain (lower) amount.

Legal insurance policies are designed to meet the legal needs of most middle-class families. They cover simple family law matters, such as simple wills, uncontested divorces, uncontested adoptions, juvenile court proceedings, minor motor vehicle proceedings (such as speeding, reckless driving, etc.) and IRS audit protection and defense services. Some plans also offer an unlimited number of phone consultations, identity theft services and immigration services.

2 Not everyone can sell legal insurance. Only a licensed insurance agent or broker can sell a legal insurance plan. And while an agent or broker can sell a legal access plan, unlicensed individuals cannot sell legal insurance. If you're not sure which type of plan would best meet your employees' needs, you'll need to talk to an insurance agent to get complete information on both.

Some companies sell prepaid legal plans using multilevel marketing. While there is nothing



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icy of the parent whose birthday (month and day) falls earliest in the calendar year. If they have the same birth date, the plan that went into effect first is primary.

- ✦ A dependent child of parents who are separated or divorced is covered first by the policy of the parent who is under court order to provide health coverage. If that parent has no coverage, coverage of the second parent is primary. If both parents have a court decree declaring them responsible, the rules are the same as for parents living together (the “birthday rule” applies). If there is no court order, primary coverage is determined in this order: the plan of the custodial parent, the plan of the custodial parent’s spouse, the plan of the non-custodial parent, the plan of the non-custodial parent’s spouse.

The NAIC model suggests that claims should be filed with each insurance plan, regardless of which coverage is primary. However, the important thing is to understand the regulations in your state and clearly explain the benefits to employees.

You can order a complete copy of the NAIC model regulation by visiting <https://external-apps.naicv/insPubs/index.jsp>

Situation Two: When Medicare is involved

The good news is that uniform rules apply nationwide to employees with Medicare.

In most cases, Medicare is primary, meaning Medicare will pay claims for covered individuals first, then you can submit any balance remaining to another policy (the second-

ary policy).

Some of the most common situations where Medicare can pay secondary are:

- ✦ The individual or his/her spouse is currently employed/working and covered under an employer group health plan.

- ✦ The company has 20 or more employees or participates in a multiple-employer or multi-employer group health plan where at least one employer has 20 or more employees.

- ✦ The individual in question is entitled to Medicare as a result of a disability; the company has 100 or more employees, or participates in a multi-employer/multiple-employer group health plan where one employer has 100 or more employees.

- ✦ The individual in question is Medicare-entitled due to end-stage renal disease. Medicare is the secondary payer to a group health plan until a 30-month coordination period has ended.

A word of warning: Wellman Shew of Shew and Company Insurance Services Inc. in California says that eligible employees of small employers sometimes do not buy optional Medicare Part B coverage, because they have group coverage. Part B covers doctors’ services and outpatient care. Group plans for small employers often assume that the company’s Medicare-eligible workers carry Part B and pay accordingly, he said, leaving these workers underinsured.

Administering a group health plan is a complicated task that requires knowledgeable and dedicated staff. For more information, please call us. ■

ing wrong with this per se, if you deal with this kind of company, check how long your salesperson has been in the field before buying a plan. You will want to deal with someone who will be there when you need service, not someone who was seduced into multilevel marketing and might be doing something else in six months.

3 Cost is a factor.

According to a 2002 article in *HR Magazine*, “...while payroll deduction programs vary in price and can cost as much as \$25 per month, experts agree that plans priced in the mid-teens are attractive to most employees.” An access plan usually costs less, between \$9 to \$12 per month, while a group legal insurance program can cost from \$12 to \$25 per month. Still, buying legal insurance on a group basis usually costs less than on an individual basis.

HR Magazine also reported, “A typical first-year enrollment figure is 15 percent to 20 percent of the workforce.” Although that might not sound high, other sources note that employees tend to opt in and out of legal plans as their circumstances change. For example, when planning to buy a house, an employee might buy legal insurance, knowing he or she could use the contract review services. By providing your employees the opportunity to buy a legal plan on a lower-cost group basis, you give them a valuable benefit that helps them balance work/life demands.

For more information on legal access plans, legal insurance or other voluntary benefits, please call us. ■

Time to Send Safe Harbor 401(k) Notices

Plan administrators must send safe harbor notices within 90 days of the start of a new plan year, but no fewer than 30 days from the start date. For most companies — those on calendar year plans — that time is now.

Notices must go to all employees who are eligible to participate in the plan. According to the IRS, the notice must be written in plain language and include information about:

- ✦ The safe harbor matching or non-elective formula used in the plan
- ✦ The level of matching contributions, if any; other contributions under the plan and the conditions under which they will be made
- ✦ The type and amount of compensation that may be deferred

- ✦ The method of making deferrals under the plan
 - ✦ The periods available for making elections
 - ✦ The withdrawal and vesting provisions applicable to contributions under the plan
 - ✦ How to obtain additional information about the plan.
- You can present some of this required information by cross-referencing to a summary plan description, but information on the plan’s withdrawal and vesting provisions must be spelled out in the written notice itself.

A safe harbor 401(k) plan is similar to a traditional 401(k), but can ease administration by eliminating the annual non-discrimination testing required under traditional 401(k)s. For more information on these plans, please contact us. ■