

Compliance Corner: Limited COBRA Obligations Under Certain Health FSAs

CONEXIS

COBRA allows qualified beneficiaries to continue group health plan coverage for a specified period of time. By designing its health FSA to meet certain criteria, an employer can limit when the health FSA must be offered under COBRA.

COBRA in General

The Consolidated Omnibus Budget Reconciliation Act Of 1985 (COBRA) amends sections of the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code, and the Public Health Service Act (PHSA). COBRA requires group health plans to offer "each qualified beneficiary who would otherwise lose coverage under the plan as a result of a qualifying event an opportunity to elect, within the election period, continuation coverage under the plan."¹

¹ Treas. Reg. §54.4980B-1,Q/A 1(a)

Healthcare: From Clipboards to Keyboards

*Executive Briefing United States
From The Economist*

America's healthcare industry has been slow to adopt information technology

"PAPER kills," Newt Gingrich likes to say these days. America's former House speaker points to Hurricane Katrina, after which many survivors suffered needlessly or died because their paper records had washed away. But the lucky few whose doctors had been wired up could retrieve electronic medical records (EMRs) nationwide. An official in New Orleans puts it bluntly: "Katrina taught us that America has to change its health information systems immediately."

The healthcare sector in North America spends surprisingly little on information technology (IT). The financial-services industry spends about \$200 billion a year on high-tech kits; health providers spend just over a tenth of that amount. But John-David Lovelock of Gartner, a market-research firm, predicts that IT's spending in healthcare will increase by an average of 4.7% per year between 2005 to

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Group Health Plan Defined

Generally, a plan is a group health plan if it provides healthcare and is “maintained” by the employer. IRS COBRA regulations define a group health plan as “...a plan maintained by an employer or employee organization to provide healthcare to individuals who have an employment-related connection to the employer or employee organization or to their families.” The regulations also state that “healthcare is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A-1), or through a cafeteria plan (as defined in Section 125) or other flexible benefit arrangement.”²

Healthcare Defined

IRS COBRA regulations state that “healthcare has the same meaning as medical care under section 213(d). Thus, healthcare generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body.”³

Health FSA Defined

Prop. Treas. Reg. § 1.125-2, Q/A-7(c) defines a health FSA as a “benefit program that provides

employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions).” Typically, a health FSA is offered under an employer’s cafeteria plan, allowing employees to contribute to the health FSA on a pre-tax basis. Employers may also contribute to an employee’s health FSA.

By electing to participate in a health FSA, an employee agrees to have a portion of his income redirected to his flexible spending account. As eligible expenses are incurred, the employee submits a claim for reimbursement. When offered under a cafeteria plan, participation in a health FSA allows an employee to pay for otherwise unreimbursed medical expenses on a pre-tax basis.

Risk Distribution

In passing the legislation that allows for cafeteria plans, Congress dictated that a health FSA must exhibit the same risk-shifting and risk-distribution characteristics of insurance.⁴ The distribution of risk between employers and employees was accomplished within the regulations with the adoption of the following rules:

The Use-It-or-Lose-It Rule. Any unclaimed funds remaining in an employee’s FSA at the

² For purposes of the 11-month disability extension. See Treas. Reg. §54.4980B-7, Q/A 5 for additional information.

³ Treas. Reg. §54.4980B-1, Q/A 1(a)

⁴ See Prop. Treas. Reg. § 1.125-2, Q/A-7

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end of the plan year (including any applicable grace period extension or run-out period) are forfeited and returned to the plan sponsor. This is commonly referred to as the use-it-or-lose-it rule.

The Uniform Coverage Rule. Under the uniform coverage rule,⁵ a health FSA participant must have access to his maximum annual election amount at any time during the plan year (minus any reimbursements for the same period of coverage). Reimbursements cannot be limited according to the participant's contributions.

When Must COBRA be Offered?

Generally, COBRA must be offered to a qualified beneficiary when there is a qualifying event. Qualified beneficiaries are eligible for 18, 29, or 36 months of continuation coverage, depending on the nature of the qualifying event. Additionally, qualified beneficiaries have the same rights, including open enrollment rights that are available to similarly-situated non-COBRA beneficiaries (i.e. active employees).

The standard COBRA rules, when applied to a health FSA, can expose the sponsoring employer to significant risk through the uniform coverage rule. For example, with the right to reenroll in

the health FSA during an open enrollment period, a qualified beneficiary could potentially elect up to the plan's annual election maximum, incur an expense, submit the claim and receive reimbursement (up to the employee's annual election amount), and then drop coverage without paying the remaining COBRA premiums. In this scenario, the employer must reimburse the claim (assuming the claim meets all approval guidelines) but cannot recoup the additional unpaid premiums.

Limited COBRA Obligation for Certain Health FSAs

The 2001 Final COBRA Regulations introduced new rules regarding COBRA and health FSAs. Under these new rules, health FSAs that meet certain criteria can limit when COBRA must be offered. To qualify, the health FSA must provide excepted benefits that are not subject to HIPAA's portability rules and meet a COBRA premium condition.

Under the final HIPAA portability regulations, benefits provided under a health FSA are excepted benefits if the health FSA is an FSA as defined in Code §106(c)(2) and satisfies the following conditions:

Maximum Benefit Condition. The maximum benefit under the health FSA must not exceed two-times the employee's salary reduction

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⁵ Treas. Reg. 1.125-2, Q/A-7(b)(2)

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election for the plan year (or if greater, the amount of the employee's election plus \$500). Health FSAs that are funded solely by employee contributions will always meet this condition.

Availability Condition. The employee with health FSA coverage must also have coverage available under another group health plan of the employer not limited to excepted benefits under HIPAA. Note that the other coverage merely needs to be available. There is no requirement that that employee actually elect coverage under the other plan(s). Employers offering other group health plans along with the health FSA will always meet this condition.

A health FSA will satisfy the COBRA premium condition if the "maximum amount that the health FSA can require to be paid for a year of COBRA continuation coverage under Q&A-1 of §54.4980B-8 (the maximum COBRA premium) equals or exceeds the maximum benefit available under the FSA for the year." In most cases, the applicable premium for a health FSA for a year will equal the annual health FSA coverage amount elected by the participant. Therefore, most health FSAs will meet this condition.

Underspent vs. Overspent

If the health FSA meets all of the above conditions, then COBRA is only required to be offered to a participating employee whose

account is "underspent." A health FSA is underspent if the cost to continue the health FSA under COBRA is less than the benefit remaining.

Example: Assume John has elected to participate in his employer's calendar-year health FSA with an annual election amount of \$1,200. John incurs no expenses prior to his termination at the end of July. At the time of the qualifying event, John has accrued \$700 in his health FSA. Typically, these funds would be lost through the use-it-or-lose-it rule. However, if John elects to continue his health FSA coverage under COBRA, he remains an active plan participant and has access to these funds (as well as the remaining \$500). In this example, the cost to continue is \$510 (the remaining \$500 in monthly premium plus the 2% administration fee paid under COBRA) while the remaining benefit is \$1,200. Because the cost to continue is less than the benefit that remains, John's account is underspent and he must be offered the opportunity to elect the health FSA under COBRA.

Conversely, if the cost to continue the health FSA under COBRA is greater than the benefit remaining under the plan, the account is "overspent" and the qualified beneficiary does

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not need to be offered the opportunity to elect the FSA under COBRA.

Example: Assume John has elected to participate in his employer's calendar-year health FSA with an annual election amount of \$1,200. John has incurred expenses totaling \$800. John has been reimbursed the full \$800 through the uniform coverage rule, even though he has only contributed \$700. In this example, the cost to continue is \$510 (the remaining \$500 in monthly premium plus the 2% administration fee paid under COBRA) while the remaining benefit is \$400. Because the cost to continue is greater than the benefit that remains, John's account is overspent and the employer is not obligated to offer John the right to continue the health FSA under COBRA.

Coverage Through the End of the Current Plan Year

In addition to the limited offer of coverage under COBRA, plans that meet the criteria outlined earlier may terminate health FSA continuation coverage at the end of the current FSA plan year. Unlike other group health plans, health FSA coverage is not required to be continued for the maximum coverage period under COBRA, nor does the health FSA need to be offered during the plan's open enrollment period.

Example: Jane has elected to participate in her employer's calendar-year health FSA. Jane is also covered under her employer's medical, dental, and vision plans which also renew on a calendar-year basis. Jane terminates her employment at the end of August and her health FSA is underspent. Jane elects to continue all coverages under COBRA, including the health FSA. Jane's coverage under the health FSA will terminate at the end of the current plan year (December 31st). While her former employer is required to offer Jane the opportunity to participate in the open enrollment period for the medical, dental, and vision plans, the employer is not required to extend re-enrollment rights for the health FSA.

Plan Design

By carefully designing its plan to meet the regulatory requirements, an employer can limit when it must offer health FSA coverage under COBRA. Ensuring that its plan meets these requirements can aid the employer in mitigating the risk presented by the uniform coverage rule. 🍷



Healthcare: From Clipboards to Keyboards

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2010, the fastest growth-rate of any industry and well above the average of 3.7%.

Technology firms sense the coming bonanza, judging by the mood at a gathering of healthcare experts held in New York on May 15th and hosted by Jeffrey Immelt, the chairman of GE. Joseph Hogan, the head of GE's healthcare division, declared that "technology will be at the heart of fixing the healthcare crisis." A spokesman for Siemens, a German rival, argued that the "explosion of medical knowledge" from the field of genomics means that information systems are no longer optional.

But there have been many previous false dawns. Steven Van Kuiken of McKinsey, a consultancy, argues that the main obstacle to EMRs is the misalignment of costs and benefits among different groups. Although large hospitals, insurers and vendors would reap big gains from computerization with quite small investments, he notes, small surgeries with just a few doctors face enormous headaches in converting from clipboards to keyboards. So they tend to be wary: a recent study by Accenture, another consultancy, estimated that barely 10% of American doctors use modern EMR systems.

In addition, many hospitals and insurers have not embraced open, interconnected EMR

systems, choosing instead to keep patient data locked away from competitors' eyes in proprietary systems. Historically, IT spending has tended to focus on payment systems and other internal processes rather than better customer service or improved outcomes. But that may be changing as a result of pressure from government, employers and consumers.

The federal government is giving a push to EMRs, following the lead of the Veterans' Health Administration (VHA). Studies have shown that, thanks in part to its sophisticated national database, the VHA has fewer patient errors and better health outcomes than the health system at large, despite the fact that its patients tend to be older, poorer and sicker. George Bush wants a system of universal health records by 2015. And Medicare, the government-run health scheme for pensioners, is shifting to a tiered reimbursement system in which it pays doctors more if they go electronic.

Employers are also keen on technology, since it promises to curb healthcare costs and improve efficiency. Intel, BP, Wal-Mart and several other big companies got together last year to form Dossia, an independent, non-profit company that will develop an EMR system to give employees lifelong, portable medical histories.

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And over a hundred other firms including Dell, IBM and Microsoft now allow employees to manage their health affairs via WebMD, a big health information Web site.

Wayne Gattinella, WebMD's boss, says the popularity of this corporate product persuaded his firm to develop a version for individual consumers, supported by "discreet" targeted ads for pills, devices or relevant consumer products. "The consumer will be the catalyst to drive doctors and community hospitals to adopt IT," he says.

Intuit, known for its accounting software, is convinced the market is ready for healthcare software too. But when it tested such a product last year, it found that users were frustrated at having to fill in so many forms and search for bills and records to which they did not have easy access. So it now plans to offer its software in conjunction with health insurers, so that payment data and other information can be filled in automatically.

Aetna, a big insurance firm, has taken a different path by acquiring ActiveHealth, a firm that provides EMRs for around 14.5 million users and also scours those health records with decision-support software to spot signs of trouble (such as missed doctors' appointments or early warnings of obesity). Aetna plans to offer this software to its own customers.

Others also hope to cash in on the expected healthcare technology boom. Around 120 firms, from Panasonic and Cisco to Kaiser Permanente, have formed the Continua Health Alliance to promote open standards and interoperability among consumer-health products. Banks are licking their chops at the prospect of "health savings accounts", and Intuit and WebMD are devising software to manage them. The prognosis for the wider adoption of technology in healthcare is finally starting to look more promising. 🍷

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More Insurers Offer Coaches for Clients to Live Better, Longer

San Diego Union-Tribune, The (KRT)

Keith Darce

After years of yo-yo dieting, that familiar and potentially dangerous cycle of losing weight and gaining it back, Mesa College accounting professor Roger Gee was ready to give up on permanently shedding some of his 321 pounds.

Then his health insurer offered a new option. Gee could team up with a health coach, a specially trained health professional who would help him develop better eating habits, an exercise routine and a new outlook tied to his desire to live healthier and longer.

The professor was skeptical at first. "I had been through other weight loss programs, and as soon as I stopped using their products I put the weight right back on," he said. "My fear was that that was going to happen again."

But this time it worked.

Gee lost nearly 75 pounds over the next year and a half, and kept it off. He started wearing clothes that hadn't fit in more than a decade. Perhaps more significantly, he underwent a necessary surgery that doctors say he likely wouldn't have survived had he not lost the weight.

Health coaching is spreading as a growing number of companies and insurers try to play a more active role in helping their workers and members stay healthy and better manage chronic diseases such as diabetes and hypertension.

Health coaching services are typically provided on a voluntary basis through health insurance plans. Nearly all of the interaction between coach and client happens over the telephone.

The coach's role can range from the mundane -- helping a client remember to take medicine properly or keep appointments with doctors -- to the more weighty, such as answering questions about insurance benefits or helping with a medical care decision.

About 44 percent of the nation's largest companies offer health coaches to their employees, according to a survey released in March by the National Business Group on Health, a non-profit group that represents large employers.

The effort could save money by keeping people off medications and out of hospitals.

Many coaching programs focus on smoking and obesity, risk factors that contribute to chronic diseases such as emphysema and diabetes.

Between 1997 and 2001, U.S. medical costs directly related to smoking totaled \$75 billion, according to the national Centers for Disease Control and Prevention. Medical costs related

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to diabetes were \$92 billion in 2002, according to the American Diabetes Association.

The San Diego County Voluntary Employee Benefits Association, which manages health insurance programs for Mesa College and other San Diego schools, started offering health coaching services about two years ago on a voluntary basis to a limited number of members with chronic health conditions.

The service costs the association about \$800 a year for each worker who uses it, but it should produce enough savings to help slow fast-rising insurance rates, said Nancy White, director of the group's health advocacy program.

"It's not a cookie-cutter approach like so many other (wellness) programs," White said. "It's one-on-one. That's what we like about it."

Health coaches are usually medical professionals with previous work experience such as nurses, dietitians, physician assistants or personal trainers. They do most of their work over the telephone or online with clients who are assigned to them long term.

In practice, health coaches often play the role of motivator, cheerleader and educator, said Elizabeth Thompson, who works as a health coach for American Specialty Health of San Diego.

"If you connect on a personal level with (a client) where your role is simply to engage them in

their hopes and dreams for themselves and their health, that's a powerful tool," Thompson said. "Everyone wants to be heard and acknowledged."

American Specialty provides personal health improvement programs to insurers and employers around the country. The company's health coach services are used by a number of San Diego employers, including the Voluntary Employee Benefits Association, Viejas Casino, the San Diego Airport Authority and Garden Fresh Restaurant, which owns Souplantation and Sweet Tomatoes restaurants.

At Viejas, operators of the Alpine casino have linked health coaching services for workers who want to lose weight and stop smoking with healthful cooking classes, daily walking groups, weekly cardiovascular exercise classes and healthful meal options in the employee dining room, said Miki Kobane, Viejas health and wellness manager.

"The major reason this program works for us is because of the accountability," Kobane said. "Team members feel accountable to take calls (from coaches). They also feel the support is totally objective. It's not a husband saying that you need to lose weight."

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Insurer HealthNet offers health coaches 24 hours a day to its 1.5 million members in California, said Lance Lang, vice president and senior medical director. The service has helped reduce hospital admissions 18 percent among members with chronic diseases who use the service.

A recent HealthNet survey indicated that most doctors like the service because coached patients tend to be better informed about their health and more helpful to their physicians, Lang said.

Nearly seven months after Gee's health coach program ended, the Mesa College professor has managed to keep off all the weight he lost. He still walks or goes to the gym every day and he cooks most of his meals at home.

Gee summed up his experience using a health coach in an evaluation he composed after completing the program.

"For years I had turned a deaf ear to the suggestions that I eat less and exercise more to lose weight," he wrote. "My wife, my children and even my doctor had given up on me. I was afraid of dying too young to enjoy my family, especially my grandchildren, and to see the world with my wife.

"So far on this journey, I have lost 73 pounds. The most important impact on my health status, however, is that I am alive." 🍌

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