



Federal Legislative Brief

Plan Year End: Compliance Highlights For Welfare Plans 2008-19

The purpose of this Memorandum is to provide Plan Sponsors with a turnkey list of welfare benefits issues which require attention between now and the end of 2008, whether or not the plans are calendar year plans. Due to the magnitude of these topics we will defer discussion of high deductible health plans/HSAs, wellness programs, and privacy rules.

For some of you 2009 benefits are fixed and open enrollments have begun or are about to begin. 2009 plan design and communications strategies are in place. For others, budget constraints are calling for significant changes in plan design. Regardless of which stage you are in, at some point before year end, you must address your plan compliance obligations. Here is our checklist.

New Compliance Required. Plan Sponsors must address the following:

- Cafeteria Plans: Compliance with new regulations;
- New Medicare Secondary Payer reporting requirements;
- New Medicare Part-D Notice content.

Year-end Federal Tax Compliance. This Memorandum provides you with an overview of IRS rules regarding the following:

- Taxation of group term life insurance coverage in excess of \$50,000;
- Tax treatment of coverage for same-sex marriage partners and domestic partners;
- Tax treatment of coverage provided to over age dependents.

Annual and Event-related Notice Requirements. We have prepared and attached as Attachment A a list of required notices you must provide employees/plan participants either annually or upon the occurrence of a specific event. You may also view the list and obtain sample notices on my website by clicking the “Compliance” button after logging into the Client Library: <http://www.abferisa.com> or contact your benefits consultant.

Details: New Compliance

1. New Cafeteria Plan Rules. For those of you who offer calendar year cafeteria plans with health care and/or dependent care spending accounts, January 1, 2009 is a very important date. By that time your cafeteria plan documents must comply with new rules and, if needed, must be amended by January 1, 2009. These new cafeteria plan rules prohibit retroactive plan amendments; so, get it right, before the plan year starts.

Written Plan Document. There must be a written plan document in place on or before the first day of the cafeteria plan year. The IRS will disqualify a plan if the plan document does not meet legal requirements.

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Usual Benefit Detail. The document must contain a description of the benefits and eligibility rules. It must include a complete description of the election procedure, salary reduction rules and any non-elective contributions and a maximum employee contribution amount. The plan must not discriminate in favor of highly compensated individuals. Elections must be irrevocable absent qualifying status changes and unused amounts must be forfeitable. And there must be a cash option.

Notable New Provisions. The new regulations contain a number of provisions a Plan Sponsor must incorporate into the plan document as well as new benefit choices available to the Plan Sponsor, at his/her discretion:

- **Common Law Employee (mandatory):** Explicit provision prohibiting participation in the plan by any individual who is not a common law employee of the Plan Sponsor.
- **Amendment and Termination Provision (mandatory):** Any amendment to a cafeteria plan must be made before the beginning of a plan year.
- **Orthodontia (voluntary):** The plan may permit reimbursement for advance payments to orthodontists even though it is for services not yet performed.
- **Dependent Care (voluntary):** The plan may permit reimbursement to terminated participants for dependent care expenses incurred after termination of employment where an account balance remains available.
- **Adoption Assistance (voluntary):** The plan may include pre-tax contributions toward the cost of adoptions which qualify under IRC Section 137..

Non-discriminatory Plan. On audit, the IRS will test a plan for passing non-discrimination tests as of the last day of the plan year. Although a Plan Sponsor may want to test for non-discrimination (using IRS rules found at IRS regulation 1.125-6) at the beginning of or during the plan year to assure compliance, the IRS, on audit, will only test as of the last day of the plan year.

Recommendation. If you have a cafeteria plan, review the existing plan document and make any necessary amendments by December 31, 2008.

2. Medicare Secondary Payer Requirements. As of January 1, 2009, insurers and third party administrators (TPAs) must collect and report information on all Medicare eligible plan participants, their coverage election including type of coverage (e.g., HMO, PPO, etc), group policy numbers (if applicable) and other data specifically on drug plan availability. Plan Sponsors may need to provide participant-specific information to insurers and TPAs in support of the CMS mandate. If a health plan is self funded and self administered, then the burden falls on the Plan Administrator/Fiduciary to meet these requirements.

Role of the Plan Sponsor. Plan Sponsors whose plans are insured as well as those whose plans are administered by large well qualified TPAs will not find the new reporting requirement burdensome. However, some TPAs for self-insured plans may not have collected all of the data necessary to meet the new reporting requirement. In that instance, the Plan Sponsor may need to collect and remit new data (e.g. HIC numbers, social security numbers, etc.) to the TPA.

If the Plan Sponsor administers its own plan, they have to choose between reporting the data itself or retaining a TPA or other vendor to do it on its behalf. In this instance the Plan Sponsor retains the ultimate responsibility for compliance.

Action Plan:

- If you self-administer a self-funded plan and you have 20 or more employees (whether part-time or full-time) you will need to review the reporting regulations when issued and determine what data you will need to collect.
- If your plans are insured or administered by a TPA, we recommend that you do the following:
 - Upon consultation with the insurer or TPA, determine what data elements are missing;
 - Assign responsibility for collecting and delivering the missing data to the reporting entity.
- If you have an existing administrative service agreement at the present time, review and modify the agreement to reflect the responsibilities of the parties for meeting these new reporting requirements.

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Seek the assistance of your benefits advisors as needed, to avoid the potentially severe penalties for non-compliance.

For detail please refer to our Legislative Update 2008-17: New Medicare Secondary Payer Requirements Impact (September 30, 2008) or go to <http://www.cms.hhs.gov/MandatoryInsRep/>.

3. Medicare Part-D Notices (Due no later than November 15, 2008):

Notice Requirement. The Center for Medicare and Medicaid Services (“CMS”) recently updated the model notices required under Medicare Part D, including the model notices of creditable and non-creditable coverage to be used by employers to notify health care plan participants whether the prescription drug benefits available under the employer’s health plan is a satisfactory substitute for Medicare Part-D.

For any notice of creditable or non-creditable coverage provided after June 15, 2008, Plan Sponsors should utilize these updated notices available at the following website: http://www.cms.hhs.gov/CreditableCoverage/09_CCAfterJune15.asp

Details: Federal Tax Compliance

As you prepare your W-2s you may need to include additional income for those employees with employer provided group term life insurance in excess of \$50,000, as well as imputed income for domestic partner coverage, same-sex marriage partner benefits, and coverage provided to over-age dependents.

1. Group Term Life Benefits. Each calendar year the cost of group term life insurance benefits provided by the employer in excess of \$50,000 is taxable to the employee. The IRS uses a table to determine the amount of income per \$1,000 per month of coverage. This imputed income is to be included on the employee’s W-2 for the year in which the coverage is provided. Although rare, it is also possible that a group term life benefit discriminates in favor of the highly compensated, resulting in the cost of all group term life insurance (using IRS Table 1 rates) to be included in the highly compensated employee’s wages. We recommend that you consult with your benefits professional for assistance in this matter.

3. Domestic Partners / Same-sex Marriages. Since federal law does not recognize domestic partnerships or same-sex marriages for federal income tax purposes, Plan Sponsors must impute income on the value of the health and other benefit coverage provided to the partner or same-sex marriage partner. The amount to impute is the fair market value of the employer provided coverage (usually health care benefits) offset by any employee after-tax contributions toward the domestic partner / same-sex marriage partner’s coverage. The fair market value traditionally used is either the premium amount for single coverage or the premium amount for employee plus spouse minus the employee premium. To calculate the imputed income please refer to the imputed income calculator Attachment B.

For example, single coverage \$350; employee and spouse coverage \$650: imputed income would be \$300 per month (offset by the employee’s after-tax contribution, if any). Since the amount of imputed income over the year can be substantial, it is important to include it in each pay check. Regardless of how you include it, this income must appear as wages on the W-2.

3. Over-age Dependents. Effective January 1, 2005, Congress amended and replaced IRC Section 152 with a new definition of dependents which may impact your health plan eligibility rules for dependent children. The new rule defines a dependent child to include a child who has not reached the age of 19 (unless handicapped) or age 24 (for full time students). For purposes of taxation, any benefit (coverage) a child receives after the date he/she turns age 24 is taxable for federal income tax purposes.

For example, if Suzanne, a full-time student, turns 24 on July 27, 2008, the employer provided group health care coverage provided from July 28, 2008 through December 31, 2008 must be reported on the employee’s W-2 based on the fair market value of his/her coverage for the period. State income tax rules in this situation vary by state.

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Recommendation. Conduct a dependent status audit based on enrollees who request coverage for dependent children who are age 18 or older. To assure responsiveness, some employers reserve the right to terminate dependent coverage in the absence of a complete response.

To make the audit effective, it is important to review and, if needed, clarify dependent eligibility rules as they appear in all plan documents, including the official plan document and the summary plan description or evidence of coverage. If there are changes, you must provide notice of the change to plan participants.

Action Items for All Plan Sponsors

1. Review your welfare plan documents and enrollment materials for consistency and inclusion of appropriate notices.
2. Review your cafeteria plan documents and amend as needed, prior to December 31, 2008 (or by the first day of the plan year thereafter).
3. Determine your compliance on imputed income and on withholding for that income as it applies to domestic partner or same-sex marriage benefits.
4. Conduct an over-age dependent status audit.
5. Determine your compliance with Medicare Part-D Notice (by November 15, 2008) and your annual notice requirements.
6. Follow the action plan shown above for Medicare Secondary Payer data collection for July 1, 2009.

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Federal Benefit Law Notice Requirements as of September 30, 2008

Annual Notices:

- Women's Health and Cancer Rights Act
- Mothers and Newborns Protection Act
- Medicare Part-D Notice
- Notice of HIPAA Special Open Enrollment Rights
- Summary Annual Reports (if applicable)

Event Driven Notices:

- COBRA General Notice (upon enrollment in a health plan)
- HIPAA Notice of Pre-existing Condition Limitations (each open enrollment)
- COBRA Election Notice (at time of a qualifying event)
- Notice of Unavailability of COBRA
- COBRA Premium Change Notice
- Notice of Insufficient COBRA Notice
- Notice of Early Termination of COBRA
- Certificate of Creditable Coverage (upon cessation of health coverage)
- Notice of Privacy Practices (upon enrollment in a health plan)
- Notice of Creditable or Non-creditable coverage for purposes of Medicare Part-D (upon change in plan effecting drug coverage)
- Summary of Material Modification (in the event of a change in plan design, carrier, etc.).

Other Notices:

- FMLA DOL Notice (posting and mail)
- FMLA Military Rights Notice (posting and mail)
- Exemption from Mental Health Parity Law (posting)
- Availability of Written Qualified Medical Child Support Order Procedures (applicable to National Medical Support Notices) (in SPD)
- Uniformed Services Employment and Reemployment Rights (posting)

DOMESTIC PARTNER AND SAME-SEX MARRIAGE PARTNER IMPUTED INCOME CALCULATOR for Federal Income Tax Purposes

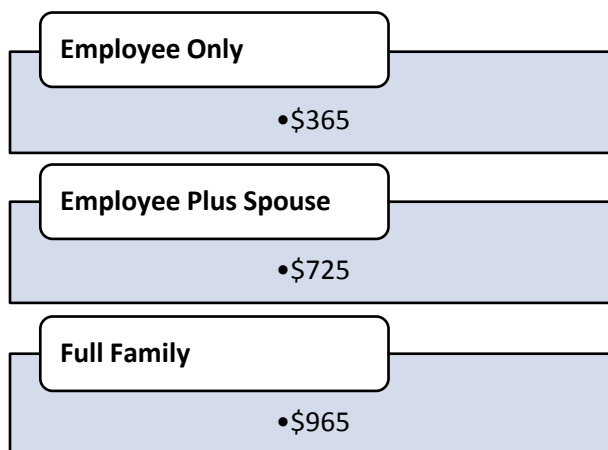
As of September 30, 2008

BASIC RULES

1. For federal income tax purposes, providing group health care benefits to a domestic partner or same-sex marriage partner (collectively: Partner) is a taxable event to the employee, requiring the employer to impute income reflecting the value of the coverage provided to the Partner.
2. The value of the coverage is the fair market value of the benefit. The IRS has never defined what constitutes "Fair Market Value." However, it has not ruled against the common practice of most employers to use the cost of spousal coverage in the employer's group policy, i.e., the difference between employee plus spouse and the employee only rate (in our example below: \$360; others just use the employee only rate: \$365.)
3. Employee contributions toward the cost of Partner coverage itself can only be made on an after-tax basis (and not on a pre-tax basis through a Section 125 premium contribution plan).

APPLICATION

Three Rate Structure (Monthly Insured Rates)



Example 1. Monthly imputed income amount for Partner coverage:

- **Most Common:** $\$725 - \$365 = \$360$ (spouse portion)
- **Some:** \$365 (employee only portion)

Example 2. Imputed income for Partner coverage and coverage for one or more dependents (of the Partner) who don't qualify as the employee's dependent(s):

- **Employee and D/P + One Dependent:** $\$360 \text{ (D/P)} + \$240 \text{ (dep)} = \$600$
- **Employee and D/P + Two Dependents:** $\$360 \text{ (D/P)} + \$480 = \$840$
- **Employee and D/P + Three Dependents (etc.):** $\$360 \text{ (D/P)} + \$720 = \$1,080$

It is important to note that each dependent child has coverage in his/her own right with a fair market value (\$240 in our example) for each dependent. As a result, in a three rate structure scenario, the income to be imputed to the employee is not limited by the employer premium amount for family coverage.

Four Rate Structure (Monthly Insured Rates)

Employee Only	•\$365
Employee Plus Spouse	•\$725
Employee Plus Child	•\$700
Employee Plus Family	•\$965

Example 1. Monthly imputed income amount for Partner coverage:

- **Most Common:** $\$725 - \$365 = \$360$ (spouse portion)
- **Some:** $\$365$ (employee only portion)

Example 2. Monthly imputed income for Partner coverage and coverage for one or more dependents (of the Partner) who don't qualify as the employee's dependent(s):

- **Employee + One Dependent:** $\$360 \text{ (D/P)} + \$335 \text{ (dep)} = \$695$
- **Employee + Two Dependents:** $\$360 + \$670 = \$1,030$
- **Employee + Three Dependents (etc.):** $\$360 + \$1,005 = \$1,365$

ADDITIONAL RULES

1. You must impute income for all benefits (medical, dental, vision, dependent life, etc.) provided by the employer to the Partner or his/her dependents.
2. You may offset the amount of imputed income by the employee’s after-tax contribution for the Partner’s coverage.

Assumption

<p>Employee Only</p> <ul style="list-style-type: none"> •Contribution: \$50 •Premium: \$365
<p>Employee Plus Spouse Coverage</p> <ul style="list-style-type: none"> •Contribution: \$110 •Premium: \$360
<p>Employee Plus Family Coverage</p> <ul style="list-style-type: none"> •Contribution: \$180 •Premium: \$240 (per child)

Example 1. Employee makes \$50 pre-tax contribution (employee-only coverage) and \$110 for spousal coverage on an after-tax basis.

• Gross imputed income:	\$360 (Employee Plus D/P)
• <u>Contributions on an after-tax basis:</u>	<u>- 110</u>
• Net imputed income:	\$250

Example 2. Employee makes \$50 pre-tax contribution (employee-only coverage) and \$130 additional for full family coverage.

• Number of Child(ren):	<u>Plus One</u>	<u>Plus Two</u>	<u>Plus Three</u>
○ Gross imputed income:	\$600	\$840	\$1,080
○ <u>Contributions on an After-tax basis:</u>	<u>- 130</u>	<u>- 130</u>	<u>- 130</u>
○ Net imputed income:	\$470	\$710	\$950

3. If the Partner qualifies as a dependent (under IRC Section 152) of the employee, there is no imputed income for purposes of federal law, for the Partner.

4. If the plan is self funded, you may use the COBRA rate for single coverage (minus 2%) to determine the fair market value of coverage for the Partner and the differential between the family COBRA rate and the employee plus spouse rate (minus 2%) to determine the value of each child's coverage.
5. If the plan uses a super grand composite rate and is insured, then use the COBRA rates as described in Rule #4 above.
6. We recommend that you include the imputed income amount in each paycheck to permit proper withholding and reporting income for tax purposes. The imputed income is earned at the time the coverage is provided. Failure to do so may result in your underreporting income, under withholding FIT, FICA, and FUTA on your periodic payroll tax reports.
7. California state law treats coverage for domestic partners who are Registered Domestic Partners as non-taxable. This rule does not apply to same-sex marriage partners. Tax treatment for coverage of dependent children follow federal rules.
8. Please refer to other sources for income tax rules for other state or local laws for the tax treatment of domestic partner or same-sex marriage partner coverage.

The purpose of this calculator is to summarize the general rules for calculating imputed income. It is not intended as legal or tax advice and may not be used as such. You are to rely on the advice of your own tax advisor in this matter.

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