

Quarterly Review

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From the Desk of the Editor

As I look back upon **2008**, there was plenty of rule making that impacted health & welfare and retirement programs: some to applaud; some not. A review of 2008 from a legal/compliance perspective is the primary focus of this issue and our featured article this quarter.

However, **2008** was also a year of campaigning and elections. There were campaigns to monitor, party platforms to dissect, candidates' positions and future projections to analyze - all within the context of how the final presidential and congressional elections might impact the broad economy but more importantly health and welfare and retirement programs – issues very near and dear to the broad readership of this newsletter.

Last November and shortly after the elections, Bob Parr, and I traveled to Orlando for an ECFC sponsored conference titled **Winds of Change**. Bob is the Sr. VP of our **Self-funded Benefits Division**, located in Ormond Beach, Florida and a frequent contributor to this newsletter. The conference keynote speaker was Grace-Marie Turner, president and founder of the Galen Institute, a public policy research organization. Ms. Turner shared with us her research indicating a global embrace of consumerism in health care. Armed with research and anecdotal evidence she made strong arguments for retaining the free market system as much as possible and minimizing the role of government in the health sector.

I admit I missed some of the nuances, but the debate between free market vs. governmental mandate and control is a debate that will doubtless grow louder and stronger as the reform movement takes shape and policy decisions are made. As we all know states have begun implementing their own governmental mandates with mixed results and some federal mandates might be helpful to iron out some of the inconsistencies. Just such inconsistencies at the state level was the original catalyst to ERISA pre-emption which employers operating nationwide have come to appreciate and value.

We had the opportunity to network with other ECFC members - all of us interested in understanding the changes ahead in preparation for setting our agenda to

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affect policy. And just to give credit where credit is due, some of my commentary had its genesis in various conference discussions with the likes of Bill Sweetnam, former counsel at Treasury and currently with the Groom Law Group, and John Hickman of Alston & Bird, as well as some 50 other industry professionals and leaders. As a former insider, Mr. Sweetnam is knowledgeable and connected and is an ally and voice on the hill for ECFC members. As an aside, it was before Bill Sweetnam in his former Treasury role, that I testified in 2003 and presented FBMC's approach to electronic payment card management. While I won't go so far as to say our approach set the standard, I will say our approach matched the approach that was deemed compliant within Revenue Ruling 2003-43 (better known as the debit card ruling).

Bob and I had dinner with our trade association lobbyists David Castagnetti, a Democratic political strategist for 20 some years, and Colette Desmaris, a former top health policy aide to Senator Grassley with 15 years experience in health care – both with Mehlman Vogel Castagnetti, Inc. Their job will be to take the ECFC agenda and present it to Congress in the way that resonates personally with each member.

And so we begin this New Year with a new Administration and new members of Congress. With knowledge gained from the conference, we have watched closely President-elect Obama's picks to posts with the most impact on health & welfare and retirement issues – no doubt you have watched as well.

Most insiders see Obama's pick of Tom Daschle as evidence he wants to move swiftly with health care reform as a priority. Daschle brings to the position knowledge of, and a personal commitment to, health care reform; and perhaps more importantly 26 years of Congressional experience (10 as Leader of the Senate) and a skill to finding common ground in dissenting opinions. No one sees Daschle's "Secretary of HHS" role focused on being the "top bureaucrat of HHS" – his

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focus will be as overseer of the Office of Health Reform; his skills will be utilized to get the reforms through Congress. I listened recently on [You Tube](#) to an interview conducted by Steve Clemons with Tom Daschle regarding his book, [Critical: What We Can do About the Health Care Crisis](#). Clemons asked several questions related to the *probability* of reform and Daschle repeated some of the axiom's of his book which I decided is a must read to really understand the depth and breadth of his reform efforts and how they mesh with candidate Obama's platform, and Ted Kennedy's reform efforts and views. Daschle told Clemons that the success of any reform rests with "leadership and bipartisanship." Daschle has demonstrated he is good at both.

Obama's Picks White House Posts		
White House Office of Health Reform	White House National Economic Council (NEC)	
Tom Daschle, Chair	Lawrence Summers, Chair	
Cabinet Posts		
Department of Labor	Treasury/IRS	Department of Health & Human Services
Hilda Solis, Secretary	Tim Geithner, Secretary	Tom Daschle, Secretary

By the way, Grace-Marie Turner (keynote speaker) produces a weekly e-newsletter titled **Health Policy Matters** that I have found informative and recommend to you. Her newsletter debates free-market ideas for health reform and is a good counter-point to ideas focused more on governmental controls or mandates. (www.galen.org)

The pick of Tim Geithner as Secretary of the Treasury was met initially with kudos for bringing to the position continuity and competence. During the recent confirmation hearings – the rhetoric vacillated between recognizing Geithner for his "global expertise in financial crisis management," and chastising him for recently uncovered past transgressions and his role in the failed bailout. As President of the Federal Reserve Bank of New York, he worked closely with Ben Bernanke over the past year so he is already up to speed on our financial woes and current strategies but as one member of Congress correctly observed - is that a good or bad thing?

By all accounts, President Obama intends to have a very formidable economic team to tackle a formidable problem. Obama's pick for Chairman of the NEC, Lawrence Summers, was Clinton's Treasury Secretary.

According to Bill Sweetnam, this pick is also noteworthy given Summer's interest in retirement issues during his years in academia. Geithner and Summer worked together previously; Geithner served as Summer's aide when he was Treasury Secretary for Clinton.

Hilda Solis, like Obama, comes from humble beginnings, her parents both immigrants. Under Solis the Department of Labor is anticipated to have a different look and feel than the Department under Elaine Chao, outgoing Secretary. Chao was criticized for favoring business at the expense of unions and workers; Solis' detractors fear that she will favor unions at the expense of corporate America. Those are two extremes neither of which we need (and neither of which are likely accurate portrayals). I agree with Senator Kennedy's sentiments that the "nation needs a leader who understands what working families face in today's economy," but just as importantly, we need a leader that understands what businesses face in today's economy and strikes the right balance between the two.

. . .

2008 may ever be known as the year the bubbles burst: the housing bubble, the stock market bubble, the collapse of old stalwarts in banking and finance, company downsizing and bankruptcies. Was it a few or many bad apples; was it because of or in spite of deregulation? The rewriters of history may tell us but whatever the final outcome and placement of blame, we will continue to feel the ripples for months, years, maybe decades to come. Employers everywhere are tightening their belts – some of you have experienced deep budget cuts, layoffs and may wonder how you will continue to provide services to your constituents or customer bases or recruit and retain qualified employees with less money for wages or other forms of compensation. We know your pain first hand.

Excitement and energy are in the air and I am optimistic, but cautiously optimistic. Many politicians have been elected with a country hoping for and in need of change; and elected believing themselves change agents. President Obama appears to have the **right stuff** but he and his team face huge challenges.

Warm Regards, Trish Neely

December Surprise: MSP Reporting Rules Apply to HRAs

Trish Neely, CFCI

Surprise may be an understatement; shock, dismay, and concern are probably closer to the truth. How administrators will be able to collect the information CMS requires for HRA participants and their

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dependants is currently being debated within FBMC and by every other HRA administrator. The biggest question on the lips of plan sponsors and administrators alike is how to offset the increased costs of administration due to the requirements of the rules. For certain, the complexity of plan administration just increased exponentially.

So what is this all about? Congress amended the Social Security Act in 2007 and added a new reporting requirement for third party administrators and insurers of group health plans. (Plan sponsors are not subject to the ruling unless they self-fund and self-administer.) The requirement referred to as **MSP Reporting Rules** was intended to provide CMS (Center for Medicare and Medicaid Services) with information necessary to assure that health plans are coordinating properly with Medicare and Medicaid. A third party administrator for purposes of the requirement refers to an entity that pays or adjudicates group health plan claims. Although FBMC is classified as a Benefits Administrator, our Self-funded Benefits Division is a TPA as that term is defined and we are currently working with our software vendor to provide CMS with its report based upon guidance issued in August of 2008. The concern is less with the reporting elements for self-funded benefits (although waiting until 8/08 to issue guidance on reports that are due 1/1/09 has caused some angst) because health plans as a matter of practice already collect most of the data elements CMS now wants. But the HRA is another story.

Although CMS confirmed as early as 2005 that HRAs are group health plans for purposes of Medicare's coordination rules, the extent to which the rules would apply to HRAs has been anything but clear and it was the general consensus of the industry that the formal guidance would **exclude** HRAs (since including them does not appear to make sense). Because like Health FSAs, the HRA Accounts may cover all dependants, most administrators have used the "self-certification of dependency status" approach to keep costs down. (e.g. *Do you certify that the dependent is your eligible tax dependent under Section 152?*) Under this new late December guidance, an HRA participant must list names, Social Security Numbers, ages, and the status of Medicare eligibility for all dependants. **At a time when we are trying to eliminate the collection of this personally identifiable information from our participants, CMS is making collection mandatory not just for the participant but also for all dependants.**

Where an HRA is tied directly to a health plan, this new requirement will have little if any impact on the HRA. This is because the date is being collected through the health plan and arrangements may be made with the insurer or the TPA to report on both the health plan and the HRA.

You will hear more about our internal initiative to comply as the months progress. For now suffice it to say, ECFC is lobbying against this new wrinkle but we are doing everything possible to comply quickly.

Trivia Question: What Section 125 Cafeteria Plan Was the First Ever Approved by the IRS?

Michael Sheridan, Chairman

Actually the IRS does not approve plans but the first affirmative private letter ruling was issued on July 11, 1986, over 22 years ago. It was issued to the School Board of Okeechobee County (Florida) for the plan created for the District by **FBMC**. Before this ruling, the IRS had taken a **cool stance** on these plans and had only issued guidance in the form of one question and answer release in 1984. FBMC, acting in consort with then District Superintendent Danny Mullins, decided that applying for the private letter ruling could give support to the many Florida School Districts that were considering offering these benefits to their employees. Although the ruling took the better part of two years to obtain, the positive impact on FBMC's reputation for quality and integrity was very significant. Before the ruling, there was a great disparity in what insurance sellers and consultants were recommending to their clients. In fact, this ruling, and the credibility that FBMC garnered, gave the company momentum in deciding to expand operations outside of Florida and become a national practice leader, a position still enjoyed today. FBMC is also glad that Okeechobee is still a client today!

As a side note, Ms. Connie Trent, the highly regarded Okeechobee County CFO, who had helped put the plan together and lead the effort to obtain the IRS ruling, is just retiring after a long and well respected career. The rest of the nation's employers who have cafeteria plans owe a debt of gratitude to Ms. Trent and the School Board of Okeechobee County for their pioneering role.

Editor's note: Michael H. Sheridan is the founder and current Chairman of FBMC. He has been an innovator and leader in the insurance and benefits business since 1965.

Proposed Café Regs remain "Proposed"

Trish Neely, CFCI

Speaking of cool stance, 2008 ended without the 2007 proposed §125 regulations becoming final and also without any formal announcement of the agencies' intent. Since a proposed regulation has little legal effect until it is finalized, only those requirements applicable under existing statute or other published final

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regulations (e.g., 1.125-4 relating to election changes) are currently in effect and enforceable.

The positive impact for FBMC and clients is additional time to comply with the non-discrimination testing requirements contained within the new proposed regulations.

Why such minimal impact? The 2007 proposed regulations codified many years of formal and informal guidance which FBMC, in coordination with legal counsel and IRS officials, had **already adopted** through the years as part of its plan management practices and procedures.

As I prepare this article, the latest **informal** guidance from IRS and Treasury is that the final regulations won't be published in final form until early next year with a likely effective date for plans beginning on or after January 1, 2010.

Feature Article

2008 - Year in Review FBMC Staff

We have pulled together some of our previous QR and Benefit Alert articles. They are condensed but we wanted to consolidate what 2008 **wrought** from a regulatory standpoint. By the way, all previous issues of this newsletter and our Benefits Alerts are posted by year to our website if you want to reread the full articles.

IIAS Rule

Effective 1/1/2008, electronic payment cards (authorized under RR 2003-43) could no longer be used at supermarkets, discount stores, or any wholesale clubs or vendors if that particular merchant did not have an inventory information approval system (IIAS) in place. (Pharmacies were given an additional year to comply.) Because these merchants do not limit their inventories to health care items they could not be granted a health care merchant category code which would have automatically approved use of the card under RR 2003-43 (debit card ruling). IIAS was the result of IRS concerns over consumer abuse that would occur when health care items and lawn chairs could both be "swiped" for purchase on the card. Health care items generally would be eligible expenses; the lawn chair would not and would result in what the industry refers to as "pay and chase" and what the IRS has little patience for.

FMLA Expanded & New Proposed Rules Issued

Effective 1/28/2008, the National Defense Authorization Act of 2008 amended the Family Medical Leave Act of

1993. Bottom line: The amendment provided up to 12 weeks of leave for any qualifying exigency if an employee's family member is called to active duty; and up to 26 weeks of leave is provided to family members of a service member injured during active duty.

Immediately thereafter, 2/11/2008, the Department of Labor issued New Proposed Rules to FMLA which attempted to address some of the challenges employers face in administering FMLA, particularly: 1) determining what is and what is not a "serious health condition," 2) verifying "medical certification and disclosure," and 3) enforcing "intermittent leave." The DOL provided a 60-day comment period for employers before issuing Final Rules. Bottom line: The Proposed Rules were helpful, but still lack clarity. To date the Final Rules remain outstanding. It may be that the DOL received a great number of comments to take under advisement in crafting the Final Rules.

TRICARE Incentive Prohibited

In March the Department of Defense (DOD) issued a proposed regulation regarding the TRICARE incentive prohibition and stated that the prohibition "applies in the same manner" as the prohibition against offering incentives under the Medicare Secondary Payer (MSP) rules. Bottom line: The Feds are making it very clear that employers may **not** incent or encourage employees off the roles of their health plans and onto the roles of the Feds' plans (TRICARE, Medicare). However, it's ok for cafeteria plans to offer a choice between taking health coverage or taking cash **as long as** this is done without regard to TRICARE eligibility.

GINA

The Genetic Information Nondiscrimination Act of 2008 was signed into law 5/21/2008 and is effective for plan years beginning on or after 5/21/2009. GINA eliminates access to genetic information by employers, health plans and health insurers except in very limited circumstances. The purpose of GINA is to eliminate discrimination based upon genetic history either in employment or in health care. GINA applies to active and retiree health plans of public **and** private employers.

Although plans/insurers may not request or require any person to undergo a genetic test for underwriting purposes, or take genetic information into account in setting group rates, they can adjust premiums based on actual claims experience. However, history of disease in family members may be collected and taken into account for payment purposes.

IRA Rollover Clarifications

Notice 2008-51 provided much needed guidance to individuals wanting to roll IRA dollars into their Health Savings Accounts (HSAs). These **qualified transfers** (from IRA to HSA) were created under the Hope Act of

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2006. The guidance includes:

- Funds may be rolled from either traditional or Roth IRAs;
- The individual must own the IRA (except in the event of death);
- Funds can be rolled from only one IRA. If an individual wants to roll dollars from more than one IRA, the funds must be rolled first to a single IRA and then rolled to the HSA; and
- Any rollover must be completed by 12/31.
- What if the individual loses HSA eligibility during the testing period? The rollover is included in gross income the tax year eligibility was lost.

HSA Grab Bag

On June 25th the grab bag of guidance on Health Savings Accounts (HSAs) was finally issued by the IRS. The guidance addressed eligibility, issues related to High Deductible Health Plans, contributions to and distributions from HSAs; and establishing an HSA.

Some bottom lines:

Participation in a limited purpose HRA that pays expenses for vision care, dental care and preventive in addition to the employee's share of HDHP premium payments is **not** a disqualifier to participating in an HSA.

A mini-med plan used to fill in gaps before the minimum HDHP deductible is satisfied is **not** a disqualifier as long as treatment is preventive or the coverage falls into the permitted category.

Employer payment or reimbursement of expenses below the HDHP deductible is **not** a disqualifier as long as the expenses paid relate to preventive or permitted coverage expenses.

Medicare is **not** a disqualifier to an HSA as long as an otherwise eligible individual is **not enrolled** in Medicare.

When an account holder turns 65, premiums for Medicare are qualified for payment through an HSA.

COBRA premiums for a spouse or dependent of an account holder are qualified for payment through an HSA.

Free or inexpensive healthcare provided at an onsite employer clinic is **not** a disqualifier as long as the clinic does not provide significant medical care.

An individual may rollover an existing HSA to a new HSA even if he/she is no longer eligible. (This is not surprising, but certainly nice to have in writing.)

Employer contributions including pre-tax salary

reductions may be made up until April 15th for a prior year (assuming the financial institution can accommodate this).

Correcting errors

1) If an employee was never eligible under §223(c) then no "HSA" ever existed and the employer may correct the error.

2) An employer may correct an error involving a contribution that exceeds the maximum contribution permitted under §223(b).

In either of these cases, the

Employer may either request return of money (less admin fees) from the financial institution or recharacterize the amount as taxable wages to the employee.

HSAs may be administered through an electronic payment card program as long as other options are also available to an individual to withdraw funds.

An account holder may not borrow from his/her HSA or use the HSA as security for a loan.

An HSA is considered "established" through States' trust laws. So, if state law requires the account to be funded to be established so be it; or if state law requires a signature, so be it. If state trust law has other requirements they must also be met in order for the account to be considered established. It is the official "establishment" date that is used to determine when qualified medical expense may be reimbursed tax-free. From an implementation standpoint, one standard (rather than state by state standards) would have made things easier to explain and to administer.

HSA administration and maintenance fees are not distributions from the HSA, instead they are reflected on Form 5498-SA in the fair market value of the HSA at the end of the taxable year.

HEART Act

May 16, 2008 Congress passed the Heroes Earning Assistance and Relief Tax (HEART) Act which made changes to some of the rules governing 1) medical (health) flexible spending arrangements (MFSA), 2) Caf e Plans, and 3) other non-health benefits. Then in October the IRS and Treasury issued additional guidance to clarify some of the tax issues and provide a clear basis for adopting the Act's provisions.

The Act is designed to help military personnel called to active duty who may otherwise forfeit dollars set aside in a medical flexible spending arrangement (MFSA). According to the Act, an employer (plan sponsor) may make a **cash distribution** of unused MFSA benefits to eligible reservists without disqualifying its cafeteria plan(s). The distribution, which the Act refers to as **qualified reservist distributions (QRD)** is completely voluntary.

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In order for the distribution to be **qualified**, four things must occur:

- 1) The individual must be a "reservist" who is
- 2) Called to active duty for 180 days or an indefinite period.

The October Treasury guidance clarified the mechanics of how this will work, what documentation is needed and what happens when the order is changed:

- a. The employer may rely on the call or order to confirm the 180 day or indefinite time period.
- b. The employer must have the **call or order** in hand before the distribution can be approved.
- c. If a call or order is less than 180 days, a QRD must not be approved; if the call or order is subsequently increased and the total period of active service is 180 days or more, a QRD may then be approved.
- d. If a QRD is approved and later the call or order is changed to less than 180 days, the change does **not** affect the previous approval.

- 3) The distribution must be for all or a portion of the balance in the employee's account.

Treasury clarified that the plan may decide the amount available as a qualified distribution:

- a. The distribution may be the entire annualized amount (also referred to by our clients as the annual election or the annual goal) for the MFSA less reimbursements received;
- b. The distribution may be the amount contributed by the reservist less reimbursements received; or
- c. The distribution may be another amount determined by the employer less any reimbursements received (as long as the "other amount does not exceed the original annualized amount).

Where the plan document does not specify the manner to determine the amount available, then the default is method "b" above.

- 4) The distribution must be made between *the date the reservist is called and the last day the reimbursement could be made for the plan.*

Treasury clarified what requests can be authorized, when the request must be made and when the distribution must be made:

- a. An individual called to active duty **before 6/18/2008** is eligible **as long as** active duty continues beyond 6/18/2008.
- b. The request for distribution **must be made** during the period beginning with the order or call and ending on the last day of the plan year. If the plan includes a grace period (don't confuse this with the runout period) then the last day of the plan year means the last day of the grace period.

- c. The request for distribution must be for the plan year in which the call or order occurred; not the previous plan year or the next plan year.
- d. The distribution to the reservist must be made within a reasonable time, not to exceed 60 days after the request for a distribution has been made.

Note: A very important date to keep in mind is 6/18/2008. Although a reservist can be called to active duty before this time, and still request and receive a distribution (item "a"), the active duty must continue beyond 6/18/2008 for the distribution to be eligible. A distribution cannot be requested for any plan years ending prior to 6/18/2008 or on any amounts forfeited prior to 6/18/2008.

The October Treasury guidance also clarified:

- A qualified reservist distribution (QRD) is included in the gross income and wages of the employee and is subject to employment taxes. The distribution must be reported as wages on the employee's Form W-2. It is reportable for the year in which the distribution is paid.
- Transition rule: Generally amendments to cafeteria plans and Medical FSAs may only be effective prospectively from the date of the plan amendment. However, this Revenue Ruling provides that an amendment made by 12/31/2009 may be effective retroactively to the date of the first QRD paid under the plan.

Part Three. The Act makes other changes to non-health employee benefit plans which do not fall under the services we provide and are mentioned for information only, including:

1. A requirement that survivors of reservists who die while deployed receive the same additional benefits that would be received if the reservist was actively employed
2. A requirement to treat differential pay as compensation for retirement plan purposes
3. A permanent extension to the 10% early withdrawal tax exception for qualified reservist distributions.

Bicycle Commuting Added to §132(f)

Tucked within the 2008 economic stabilization legislation was a new fringe benefit: - **bicycle commuting**. The benefit was not a surprise since it has been on and off the table for discussion for several years. The surprise was that the final product is an employer paid benefit only. So while Employers may reimburse employees on a tax-free basis up to a monthly maximum, the benefit cannot be funded with Employee pre-tax salary reductions. The maximum benefit toward eligible expenses incurred is \$20 per month for each month the employee uses his/her bike for a **substantial** portion of travel to and from work

(substantial left undefined). Unlike other fringe benefits, the amount will not be indexed for cost of living adjustments. Details remain sketchy but what we do know is that eligible expenses include cost of purchasing a bike, bike improvements, repair, and storage. Reimbursements must be submitted and made no later than 3 months following the calendar year in which expenses are incurred.

QTB Card Guidance Delayed Revenue Notice 2008-74

As some transit systems continued to experience technology barriers to achieving compliance, the effective date was delayed to 1/2010 on previous IRS Guidance which paved the way for the use of electronic payment cards as transit expense **vouchers**. Using the card as a voucher would eliminate the need for full substantiation and certification of the expense and keep down the costs of administering this program. Our fingers are crossed that transit systems will solve their technology barriers soon.

Newborns' & Moms' Health Protection Act (NMHPA) of 1996, Final Rules

The US Department of Labor (DOL), Treasury, and Department of Health & Human Services (DHHS) published final rules that provide guidance in complying with the provisions of NMHPA. The rules, published in the Federal Register on 10/20/2008, are effective with plans on or after 1/1/2009 and replace interim final rules adopted in 1996. In general the interim rules **are** the final rules.

The primary purpose of the 1996 Act was to protect Newborns and Moms from being discharged from hospital care too early following childbirth. At the foundation was (is) a general rule that group health plans or health insurance issuers (for individual coverage) cannot restrict benefits for a hospital length of stay in connection with childbirth to less than 48 hours, or 96 hours in the case of cesarean section.

An important clarification in the final rules was to the definition of **attending provider** – it does not include a plan, hospital, managed care organization, or other issuer. The attending provider is the individual providing direct care to the Mother (doctor, nurse, midwife, etc). Thus the following provisions of the 1996 Act read within that context, give only the Mother and her doctor/nurse/midwife control over aspects of childbirth, including when the clock starts ticking, and the ability to end the stay before 48 hours have elapsed. The rules:

- Provided that the attending **provider** determines that an admission is in connection with childbirth;
- Provided an exception to the general 48-hr rule if the attending provider and the Mother agree to an earlier discharge;

- Determined that the hospital stay begins (the clock starts ticking) at the time of delivery and not at the time of admission or start of labor;
- Clarified within the authorization and pre-certification requirements that a health plan or issuer may not require pre-authorization to prescribe a hospital length of stay that is subject to the general rule;
- Explained that cost-sharing rates must be consistent throughout the 48 or 96-hr stay, and not less for a shorter stay;
- Stated the prohibitions of offering incentives or disincentives to Mothers or to attending **providers** to encourage a shorter stay;
- Included the statutory notice provisions under ERISA and PHS; and
- Included an exception to the Act's requirements if a given state's laws meets any of three criteria:
 1. 48-hr or 96-hr length of stay requirement following childbirth;
 2. require coverage in accordance with established professional guidelines; or
 3. require length of stay decisions to be left up to attending provider and mother.
- The final rules confirm that it is not necessary for states' laws to include all of the federal provisions in order for health insurance coverage in those states to be excepted from the federal requirements. [emphasis added]
- Clarified that the final rules do not require non-hospitals or other facilities (birthing centers) to comply with the 48-hr stay minimum;
- Confirmed a plan could apply less favorable cost sharing in connection with childbirth if the individual failed to satisfy the plan's advance notice requirements; however, any variance must apply consistently throughout the stay. Again the agencies are ensuring that there is no inducement or incentive to release early.

With the exception of nonfederal governmental plans that have opted out of the Public Health Services Act, **self-insured plans** in all states generally are required to comply with NMHPA's federal requirements.

True Mental Health Parity Required

Included in the economic stabilization legislation signed by President Bush was the Mental Health Parity & Addiction Equity Act of 2008. This Act expands and amends the existing Mental Health Parity Act and removed the Act's sunset provision.

The legislation clarified that group health plans are prohibited from adopting mental health or substance abuse benefits with treatment limitations, financial requirements, benefit caps, or out-of-network limitations that are less generous than for other types of benefits in the health plan.

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It is important to note that this federal Act does not mandate inclusion of mental health or substance abuse benefits; however, states' insurance laws may have such mandates in effect for insured plans. The federal parity act requires that if the group plan has mental health or substance abuse benefits in place (either voluntarily or by state mandate) then there must be true parity with other benefits. Plan sponsors and their medical providers must begin reviewing their group health plans now to bring them into compliance. The Act is effective for plans beginning on or after 10/9/2009.

Exceptions. The legislation does not apply to small employers (50 or fewer employees). The Act contains a provision whereby an employer may request an exemption if upon implementing the Act's provisions it can demonstrate (actuarially) a 2% increase in rates during the first year; or 1% for subsequent years. The exemption is for one year at a time. In practice this means complying with the Act, if rates increase an employer may apply for a one year exemption; next year comply with the Act again, if rates increase apply for another exemption, and so forth.

Michelle's Law

October 9, 2008, Congress enacted a law to restrict when a group health plan may terminate coverage for a covered "dependent child." Congress was responding to a highly publicized story of a student who died shortly after graduation, due in part to her refusal to quit school as her doctor's recommended because doing so would have terminated her health coverage under her parents plan. The law is effective for plan years beginning on or after 10/9/2009.

For purposes of the law the "dependent child" must have been a student enrolled in post-secondary education immediately before the medical leave of absence. Under the law, a health plan may not terminate the "dependent" for one year following the first day of the medically necessary leave, or the date that the coverage would otherwise have terminated, whichever is earlier. The law also requires that group health plans include notice of the requirements along with any notice regarding certifying student status for plan coverage.

IIAS or 90% Rule for Pharmacies Delayed

Notice 2008-104 issued 12/4/2008 delayed the mandatory effective date until July 1, 2009. Merchants with Pharmacy Category Codes had two methods to comply with various rulings that permitted use of electronic payment cards for health purchases. They could either put into effect an IIAS (Inventory information approval system) as other non-health merchants were required to do effective 1/1/2008, OR they could demonstrate on a store-by-store basis that 90% of the store's previous year total gross sales were for medical care items. Many merchants opted for the

90% rule but then discovered that they were unable to satisfy this requirement. The additional 6 months was provided presumably to give them time to instead implement IIAS.

2009 COLAs

Muriel Etienne, CFC

Mileage Rate To Obtain Medical Care

In Revenue Proc. 2008-72, issued 11/24/2008), the IRS announced that the standard mileage rate for use of an automobile to obtain medical care will be \$.24 cents per mile for 2009. Transportation expenses that are deductible medical expenses under Code Section 213 generally can be paid or reimbursed on a tax-free basis by a Medical (Health) Flexible Spending Arrangement (MFSA), Health Reimbursement Account (HRA), or Health Savings Account (HSA) as long as the expense is primarily for, and essential to, medical care.

Dependent Care Flexible Spending Arrangement

The dependent care statutory limit has not changed for the 2009 plan year however; there are some new 2009 tax limits which are relevant to the federal income tax savings benefits received through a DFSA. Changes have been made to the 2009 tax rate tables, the personal exemption amount and the standard deduction amounts.

Social Security Taxable Wage Base

In its 2009 Fact Sheet, the Social Security Administration (SSA) announced last October that the taxable wage base will increase from **\$102,000 in 2008 to \$106,800 in 2009**. You are considered a highly compensated (HCE) if your annual salary is **\$110,000** in 2009, compared to **\$105,000** in 2008. For a copy of SSA's 2009 Fact Sheet, access the following link: <http://www.ssa.gov/pressoffice/factsheets/colafacts2009.htm>.

Tax-Favored Arrangements

On October 16, 2008, the IRS issued Revenue Procedure 2008-66, giving taxpayers an overview of the 2009 cost-of-living adjustments (COLAs) related to standard deductions and many other indexed adjustments (see tables below).

QUALIFIED TRANSPORTATION BENEFITS (\$132)		
2009	2008	Transportation Costs
Monthly Contribution Limits		
\$120	\$115	Commuter and Transit Pass
\$230	\$220	Qualified Parking

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INDIVIDUALS		
2009	2008	Tax Filing Status & Exemption
\$11,409	\$10,900	Married Individuals Filing Jointly and Qualifying Widow(er)
\$5700	5450	Married Individuals Filing Separately
\$8350	8000	Head of Household
\$5700	5450	Single (unmarried individual other than HH and Qualifying Widow(er))
\$3650	3500	Personal Exemption (Phases out based on status and AGI)

HEALTH SAVINGS ACCOUNTS (HSAs)		
2009	2008	Type of Coverage
Annual Contribution Limit		
\$ 3,000	\$ 2,900	Self-only Coverage
\$ 5,950	\$ 5,850	Individual with Family Coverage
Annual HDHP Out-of-Pocket Expenses cannot exceed:		
\$ 5,800	\$ 5,600	Self-only Coverage
\$11,600	\$11,200	Individual with Family Coverage
Annual HDHP Deductible cannot be less than:		
\$ 1,150	\$ 1,100*	Self-only Coverage
\$ 2,300	\$ 2,200*	Individual with Family Coverage

Note: the new \$20 per month Bicycle Benefit is not included in the QTB table (page 8) as it will not be indexed annually for inflation.

RETIREMENT VEHICLES (§§ 401(K); 403(B); 457; IRA)		
2009	2008	Annual Limits
\$16,500	\$15,500	Elective Deferrals 401(k) & 403(b) <i>excludes adjustments & catch ups</i>
\$16,500	\$15,500	Limits for 457(b)(2) and 457(c)(1) <i>excludes catch ups</i>
\$5,500	\$5,000	Catch up Deferrals (401(k), 403(b), and 457 plans)
\$5,000	\$5,000	IRA - individuals aged 49 or below
\$6,000	\$6,000	IRA - individuals aged 50 or above

Retirement Plan Services

403(b) Plan Document Deadline Extended

Patrick Peters, CFC

On December 11, 2008, the Internal Revenue Service issued Notice 2009-3, extending the deadline for the adoption of a written plan document for Section 403(b) plans to December 31, 2009.

Final regulations under § 403(b) were published on July 26, 2007. Effective January 1, 2009, sponsors of §403(b) plans are generally required to maintain a written plan that satisfies, in both form and operation, the requirements of the final regulations. Although many sponsors of § 403(b) plans have already adopted a written § 403(b) plan, the IRS and Treasury are aware that some sponsors may not have a written § 403(b) plan in place by January 1, 2009.

The new Notice will not treat a § 403(b) plan as failing to satisfy the requirements of § 403(b) and the final regulations during the 2009 calendar year, provided that:

√ On or before December 31, 2009, the plan adopts a written § 403(b) Plan Document that is intended to satisfy the requirements of § 403(b) and the final regulations effective as of January 1, 2009;

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√ During 2009, the plan operates in accordance with a reasonable interpretation of § 403(b), taking into account the final regulations; and finally

√ By 12/31/2009, the plan makes best efforts to retroactively correct any operational defects in order to bring the Plan into compliance with the written § 403(b) plan.

2009 Minimum Distributions Suspended

By Patrick Peters, CFC

Good news! In an effort to allow participants to keep the remaining money in their retirement account(s) and possibly recover some losses, Required Minimum Distributions (RMDs) have been waived for 2009.

The Worker, Retiree, and Employer Recovery Act of 2008 (The Recovery Act) signed into law, December 23, 2008, waives required minimum distributions (RMDs) for all defined-contribution plans for 2009.

The waiver applies to all defined contribution plans, including 401(k), 403(b), 457(b), and IRA accounts. It applies regardless of a participant's total retirement account balances.

Before this waiver, participants were required to make withdrawals based on the size of their account and their age every year after age 70 ½. Those who failed to take an RMD were heavily penalized with taxes equal to 50 percent of the amount not withdrawn.

Proposed Rule Making

Trish Neely, CFCI

Early this month Senator Max Baucus, Chairman of the Senate Finance Committee advised the media that Congress had agreed to include COBRA subsidies in the latest economic stimulus bill. Thereafter, Representative Charles Rangel proposed an economic stimulus bill - **American Economic Recovery and Reinvestment Plan** - that includes a number of health plan related provisions that will impact our programs. The details can be found in a document prepared by the Joint Committee on Taxation, published 1/21/09 and scheduled for review in the House Ways and Means Committee the following day. We are including a brief summary of the possible impact upon COBRA and HIPAA in this issue followed by a **Benefits Alert** as more information becomes known. In the interim, for more information we recommend the following:

Joint Committee on Taxation - "*Description of Title III of H.R.598, the Health Insurance Assistance for the Unemployed Act of 2009*," www.jct.gov; and

House Committee on Ways and Means - "*Summary of COBRA provision in the economic recover package*",

<http://waysandmeans.house.gov/media/pdf/110/cobra.pdf>

Proposed Rule Making: Impact on COBRA

Muriel Etienne, CFC

Congress is focused on stimulating the economy and also diminishing the roles of the under- and un-insured.

Title III of the American Economic Recovery and Reinvestment Plan is the **Health Insurance Assistance for the Unemployed (HEALTH) Act of 2009** (H.R. 598). Based upon what we have read in the Act, and assuming the proposed rule making becomes law, the Act would **1)** subsidize COBRA premium costs and **2)** extend COBRA coverage for certain individuals. From our review, here's how it will work:

COBRA Premium Assistance

The subsidy will act as a tax credit and cover 65% of the employees COBRA premium for a maximum of 12 months. Qualifying individual will be required to pay 35% of the premium and the employer will be ultimately reimbursed by the federal government through a payroll tax credit and directly reimbursed if the subsidy amount surpasses the employer's payroll taxes.

The subsidy will apply to individuals who involuntarily terminated September 1, 2008 through December 31, 2009 and their eligible dependents. An individual having previously opted not to enroll will be granted a special 60 day enrollment period starting on the date of the laws enactment.

COBRA Coverage Extension

Eligible employee aged 55 or older OR having 10 or more years of service may be granted an extension (at their own expense) to COBRA benefits that would have ended on or after the Act is passed. The benefit coverage extension would be effective until the qualified individual elects to enroll in the Medicare program or his/her employer terminates all group health plans. The extended coverage would also apply to all qualifying dependents.

Coverage under State Medicaid Program

The Act permits the federal government to match 100% of the costs of benefits and administration; and permits States the option to offer coverage to involuntarily unemployed and uninsured individuals and their dependents who :

- 1) receive unemployment insurance benefits or who have exhausted unemployment insurance benefits;
- 2) have income below 200 percent FPL (\$42,400 for a family of four) and are not otherwise eligible for Medicaid or CHIP;
- 3) receive food stamps who are not otherwise eligible for Medicaid or CHIP.

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Qualifying individual will include employees involuntarily terminated September 1, 2008 through December 31, 2009.

- √ Will there be income related criteria associated with subsidy eligibility?
- √ How will previously paid COBRA premiums be handled?

There are unanswered questions. Hopefully all will be revealed with the bill's passage.

Proposed Rule Making: Impact on HIPAA

Trish Neely, CFC

Title IV of the American Economic Recovery and Reinvestment Plan is called the **Health Information Technology for Economic and Clinical Health Act (HITECH)**. This Act expands the scope of HIPAA's privacy and security provisions and importantly for Business Associates, applies the security standards for administrative, physical and technical safeguards.

As FBMC's Privacy Officer I made the decision in 2003 that FBMC would operate as if the Privacy and Security rules applied to us even though we were not (and are not) a covered entity as that term is defined by HIPAA for purposes of administering our client's plans. We believed that it was a wise approach and if this bill passes, that decision will mean we are already in compliance. However, the additional privacy requirements must be incorporated into the business associate agreements currently in place with all plans.

In addition to applying the security standards to Business Associates, the Bill also applies the civil and criminal penalties to Business Associates who violate these security standards.

The Bill defines what a "breach" is and what it isn't which is welcome news. A breach is the **unauthorized acquisition, access, use or disclosure of PHI which compromises the security, privacy or integrity of PHI maintained by or on behalf of a person**. A breach is not the unintentional acquisition by an employee or agent of the covered entity or business associate if such access was made in good faith and if such information is not further acquired, accessed, used or disclosed by such employee or agent.

The Bill identifies notification procedures, who is responsible for compliance, timelines, and annual reporting requirements to the Department of Health and Human Services (HHS).

The Bill directs HHS to publish guidance within 60 days after the date the Bill is enacted specifying the technologies and methodologies that render PHI

unusable, unreadable, or indecipherable to unauthorized individuals.

Other Privacy Rule Changes

The Bill extends individuals' rights to request restrictions on certain disclosures of PHI by requiring the plan sponsor/covered entity to comply with the requested restriction unless otherwise required by law if it is a disclosure to a health plan for payment or healthcare operations and the individual has fully paid the provider for the health care item.

A covered entity will only be in compliance with the minimum necessary requirements if it limits, uses, disclosures and requests PHI to a "limited data set."

Expands the list of organizations where a covered entity must enter into a business associate agreement in order to share data, including: Health Information Exchanges, Regional Health Information Organizations, E-prescribing Gateways, vendors of Personal Health Records who have entered into contracts with covered entities.

Enforcement

The Bill clarifies that criminal penalties for violations of HIPAA can be applied directly to individuals whether they are employees of covered entities or have no relationship to covered entities.

Under the Bill, HHS is instructed to have a formal investigation of complaints with civil monetary penalties for violations that rise to the level of willful neglect.

The Bill authorizes State Attorneys General to enforce the Federal privacy and security laws. Since many states have their own laws related to privacy and security it will be interesting to see how this would play itself out.

More to come if/when this bill is enacted.

COBRA for "Dummies"

Desso H. Forman, CDHC

With the discussion at the Congressional level about changes to COBRA, it was only fitting that I attend a class on COBRA as part of my continuing education series required by the State of Florida to retain my insurance license. What follows is a brief overview of some of the issues revolving around COBRA. As you know from the previous article **Proposed Rule Making: Impact on COBRA** (page 10), Congress is contemplating some changes. But until then:

Background

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Internal Revenue Code

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in the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHSA).

COBRA is a law about the continuation of certain insurance benefits when participants lose insurance eligibility because of specified events. The length of continuation is determined by the reason for the loss of coverage.

COBRA is an **employer** liability law and not an insurance law. Although employers may have a third party (Health Insurance Company or TPA) handle the administration of complying with the law, the employer is **responsible** for the administration and liability. Failing to comply could result in one or more of the following:

- Excise tax
- ERISA penalties
- Pay the Claim
- Damages
- Attorney fees

Compliance - Employer

For employers who must comply, the employee count "test" is determined on a January 1st to December 31st time frame.

All health plan sponsors having 20 or more employees (over half the typical business days in the preceding calendar year), must comply with COBRA continuation provisions for participants losing insurance during the next calendar year. Eligibility for insurance is not a determining factor. The 2001 guidelines use a full-time equivalency formula when counting part-time employees (Number of hours worked as Part Time divided by Number hours required to be Full Time = Full-time equivalent ratio).

All employers are subject to COBRA with the exceptions of :

- The Federal Government
- Church Plans (as defined in section 414(e) of the IRS Code

However, a Day Care Center run by a church would be subject to the law.

Compliance – Qualified Beneficiary

A qualified beneficiary is an individual covered under the employer's health plan the day before the COBRA qualifying event. The law defines a qualified beneficiary as a covered employee, covered legal spouse of the employee, covered dependent of the employee or, as provided for by the HIPAA law, any child born to, or placed for adoption with, the covered employee during the continuation coverage.

Qualified beneficiaries have other special benefits through the COBRA law that an employer should review. In addition, the COBRA law provides benefits for NON-Qualified Beneficiaries. Again, review COBRA laws governing this group.

IMPORTANT: Each qualified beneficiary has his/her own individual right to continuation. Nothing is contingent upon the employee continuing coverage.

Compliance – Plans that must be included

For COBRA purposes, "a group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have employment-related connection to the employer or employee organization or to their families."

"A group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization."

Plans governed by COBRA:

- Medical
- Dental
- Vision
- Rx
- MFSA – medical reimbursement account (under certain conditions)
- Employee Assistance Programs
- Health Reimbursement Arrangement (HRA)

Compliance: Notification, Election, Payment

Employee Notifies Employer - In events where an employer may not be aware (legal separation, divorce or dependent no longer eligible) the employee or qualified beneficiary has **60 days** to notify the employer of the event.

Employer Notifies Administrator – If employer has outsourced their COBRA notification obligation, the employer has **30 days** to notify the Administrator.

Notice to Beneficiary – COBRA continuation notification must be provided the later of **14 days** of the coverage end date or **14 days** of notification – if the COBRA Administrator and the Plan Administrator are the same, the 2004 regulations provide for a **44 day** timeline to provide the COBRA Notice.

Qualified Beneficiary Elects Coverage - The election period ends **60 days** from the later of, the date the notice is provided or coverage ends.

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The initial payment for COBRA coverage must be sent within **45 days** of the election and must bring the qualified beneficiaries to a current paid status

Subsequent payments must be sent within **30 days** of the due date.

This was strictly an overview of COBRA. There are many areas of compliance where you should seek legal counsel to understand and comply with all the nuances of this employment law.

Benefit Trends

Desso H. Forman, CDHC

In August of 2008 MetLife conducted its sixth annual Study of Employee Benefits Trends among employers and employees to gauge trends and perceptions for the two groups. The questionnaire sent to 1,380 full-time employees and 1,652 benefits decision-makers nationwide, was distributed in August of 2008 and the results were released in fourth quarter of 2008.

Here is a summary of the basic findings of the study:

- Employees are poised to take a more proactive role in planning for the future, and are looking to their employers for advice and guidance.
- While employers are seeing more of a link between benefits and employee retention than ever before, they still underestimate how important a factor benefits are in loyalty.
- Employers' perception of how loyal they are to employees differs from employees' perception.
- As employees focus on retirement, the need for employers to address benefits for retirees is growing.

I recently sat through a meeting conducted by the author of the study, Dr. Ron Leopold, who believes that we need to rethink the conclusions in the study. As we are all aware, our financial world and many elements that affect it have been turned upside down.

With that in mind, MetLife has decided to resend the questionnaire and it will be interesting to see if the findings hold true. My own predictions:

- The perception by employees to take a more proactive role in planning for the future **will deepen** with the additional financial pressures on both the employer and the employee.

- Benefits as an employee retention tool will have less importance to some employers for two reasons:

- 1) less pressure to retain talented employees with a flush job market
- 2) "survival" may mean cutting benefits drastically just to stay in business

- The perception gap of loyalty between employers and employees will widen.

- Addressing retiree benefits will still be an issue. However, retiree benefits may move down in priority.

By the way, I am not advocating any of these predictions just stating some facts based upon my years in the industry. Although when times get tough, individuals tend to shore up their risk and buy more "insurance," that fact does not always translate into employer decisions or actions.

After the updated study is released sometime late first quarter or early second quarter we will take a look at the contrasts of the two studies and what it may mean for benefit professionals, employers and their employees. We should all have a much clearer picture of economic as well as health care reforms moving through Congress and can provide you with some analysis for planning purposes.

Political Trends

From the Editor: We close this issue the way we began, talking "politics;" not something we typically do in this newsletter.

But the perspective is from the standpoint of knowledge; of trying to understand the nuances of the "**politics**" rather than espousing a political point of view. However, we sometimes lean in a particular direction - always toward the side of any reform that reflects or benefits our broad customer base.

Now that the elections are behind us and the sleeves are rolled for action I asked Jim Crews to synthesize the past six months of knowledge gained about then candidate Obama's health reform platform with now President Obama's and Congress' actions. As a former elected official and lobbyist, Jim Crews has been involved in healthcare issues at local, state and national levels. In 2008, as our Leadership Team looked for an individual to wade through the spin and help us stay abreast of key candidate and platform issues, Jim was a natural choice.

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On Healthcare Reform

Jim Crews

Both in the White House and Congress healthcare reform is on the front burner. President Obama's economic stimulus plan positions healthcare as an important foundation for financial resurgence and recovery.

A key gauge of the President's commitment was his naming of former South Dakota Senator Tom Daschle Secretary of Health and Human Services. Daschle's healthcare knowledge is extensive and solid; he has an unquestionable rapport with Congress on both sides of the aisles – critical ingredients to success.

At the core of Candidate Obama's proposals (and there is no evidence that these have not remained President Obama's proposals) were employer-based health plans with a mandate for medium and large employers to provide "meaningful" coverage for their workers or pay into a national fund.

This proposal to require employers to automatically enroll their workers in employer-based health plans will add about five million Americans to the ranks of the insured, according to the Urban Institute Health Policy Center.

The President also envisions a National Health Insurance Exchange where small businesses and persons ineligible for employer-based plans or public programs can purchase health insurance from a new public plan or eligible private plans. His proposal requires health insurance for all children, provides tax credits to small employers for employee coverage, expands Medicaid and SCHIP and includes income-related subsidies to help people buy qualified insurance. In was to this mandate that Candidate Obama's approach differed most from Candidate Clinton's. Hillary Clinton would have pressed for mandated coverage for all Americans and this is still very much an agenda for some in Congress as you will see below in the Baucus **Call to Action**.

In Congress the Democratic majority is postured to move forward as early as this year, while the President may be looking at his first term. Senator Max Baucus (D-Montana), Chairman of the influential Senate Finance Committee, released his vision for healthcare reform immediately after the election. Sen. Edward Kennedy (D-Massachusetts), Chairman of the Senate Health, Education, Labor and Pensions Committee, is committed to reform, and the two senators are working together.

Sen. Baucus' 84-page Call to Action reflects the leadership's interest in immediate wide-ranging reform.

Like President Obama, Sen. Baucus believes you cannot have economic reform "without fixing healthcare." The Senator's plan builds on the employer-based system. Large employers must offer coverage and make a contribution; otherwise, employers will have to pay into a fund. The plan includes a nationwide Health Insurance Exchange (similar to Obama's plan) giving individuals without employer-based coverage access to private coverage or a public plan. Unlike the President's proposal, the Baucus plan includes a mandate that all individuals obtain coverage.

As expected, analysts and elected officials are beginning to comment, and there is not unanimity among the members, perhaps more so in the House than in the Senate.

This week House Majority Whip James Clyburn (D-South Carolina) said he feels comprehensive health care legislation will not pass in 2009, at odds with the Senate timetable. Mr. Clyburn favors an incremental approach. After the elections, Rep. Pete Stark (D-California), chairman of the House Ways and Means Committee's health subcommittee, said Congress could vote this year or early 2010.

The two plans await specifics and cost estimates, though the President repeatedly states reducing costs, for instance through prevention and health IT, is central to his plan. For the moment Mr. Obama has not said when he will move forward with a healthcare measure.

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