News Scan

GRS
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Consultants & Actuaries

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The following news summaries were developed by Gabriel, Roeder, Smith & Company to inform clients and other benefit professionals of news in the benefits industry. Our thanks to Mary Ann Vitale for her diligent work on this issue. To receive this publication electronically, send an email to web.admin@gabrielroeder.com with the message "SUBSCRIBE NEWS SCAN" in the subject line. To stop receiving this publication electronically, send the message "UNSUBSCRIBE NEWS SCAN" in the same manner. Copies of this and other benefit-related publications are available on the GRS web site at www.gabrielroeder.com.

Note: The authors of these news summaries are not attorneys and the statements made are not legal advice or opinion. Qualified legal advice should be obtained before acting with regard to related laws and regulations.

President Signs Health Opportunity Patient Empowerment Act

On December 20, 2006, President Bush signed the Health Opportunity Patient Empowerment Act of 2006 (H.R. 6134) into law. The new law enacts parts of the Tax Relief and Health Care Act of 2006 (H.R. 6111), recently passed by Congress. The provisions of the new law are designed to improve health savings accounts (HSAs), including:

- **Allowing one-time rollovers from FSAs and HRAs into HSAs:** Under the new law, employers can transfer funds from an employee's flexible spending account (FSA) and health reimbursement account (HRA) into an HSA for employees switching to an HSA-compatible health plan. The maximum transfer amount is the balance in the FSA or HRA as of September 21, 2006, or if less, the balance as of the date of the transfer. The provision is limited to one distribution with respect to each health FSA or HRA of the individual. Transfers can be made through December 31, 2011.
- **Increasing the annual HSA contribution:** Prior to the new law, the maximum HSA contribution was the lesser of the deductible for the individual's HSA-eligible plan or the statutory maximum ($2,850 for individual coverage and $5,650 for family coverage in 2007, indexed for inflation). For taxable years beginning after December 31, 2006, the new law repeals the annual deductible limitation on HSA contributions and allows contributions up to the statutory maximum.
- **Permitting one-time transfers from IRAs to HSAs:** Prior to the new law, funds in IRA accounts could not be transferred to HSA accounts. For taxable years beginning after December 31, 2006, the new law allows a one-time, trustee-to-trustee transfer from an IRA to an HSA, provided total HSA contributions do not exceed the maximum amount for the year.
- **Allowing earlier indexing of cost-of-living adjustments:** Prior to the new law, the HSA contribution limits were indexed for inflation based on the 12-month period ending August 31. Beginning in 2008, the new rules base indexing on the 12-month period ending March 31, and require that the adjusted amounts be published by the Treasury Secretary before June 1 of the year preceding the year they apply. This would give HSA sponsors and participants more time to make decisions about health care for the coming year.

A summary of the Act is available at: http://benefitslink.com/pr/detail.php?id=40252

Ice Miller Posts Retirement Programs Comparison Chart

In November 2006, the law firm of Ice Miller posted their *Retirement Programs Comparison Chart,* contrasting the key features of tax-qualified retirement programs under the Internal Revenue Code (IRC). Retirement programs summarized in the chart include: 401(a) defined benefit and defined contribution plans, 401(k) plans, 403(b) plans, and 457(b) plans maintained by governmental employers. Some of the features compared among the plans include: eligibility, vesting, contribution limits, catch-up contribution limits, and minimum distribution requirements.

The chart is available at: http://www.icemiller.com/retirement_programs_comparison_chart.pdf

New Jersey Legislative Committee Issues Public Employee Benefits Reform Report

On November 27, 2006, the bipartisan New Jersey Joint Legislative Committee on Public Employee Benefits Reform issued an extensive 188-page report with over 40 recommendations for proposed changes in the state's public employees' benefits system. The committee was one of four committees established for a special legislative session to enact reforms intended to reduce New Jersey's property taxes. It examined pension, health and other employee benefits and developed proposals aimed at reducing and containing costs. The committee's recommendations included: limiting pension plan participation to full-time career employees; increasing the age for unreduced pension benefits from 55 to 62 (applicable to new employees); repealing the law establishing a nonforfeitable right to pension benefits (applicable to new employees); and requiring current employees and future retirees to pay a portion of health insurance premiums.

After the report was issued, the committee proposed legislation based on its finding. On December 7, 2006, New Jersey Governor Jon S. Corzine requested that legislative leaders remove or revise 11 provisions related to health care benefits under consideration by the committee. Generally, in New Jersey, changes in heath care benefits for state workers are negotiated through collective bargaining. Given that the State's contract with state workers expires June 30, 2007, the Governor noted that efforts to negotiate structural and cost-saving reforms in the collective bargaining agreements might be compromised if the health care changes were legislatively mandated.

The committee's report is available at:
http://www.njleg.state.nj.us/propertytaxsession/opi/jcpe_report111506.pdf

Medicare Part D Study Analyzes Beneficiary Enrollment in 2006

On November 21, 2006, the online edition of *Health Affairs* journal published an article titled, *Status Report on Medicare Part D Enrollment in 2006: Analysis of Plan-Specific Market Share and Coverage.* The study examined Part D enrollment by plan type, benefit design, and gap coverage. According to the authors, Juliette Cubanski, principal policy analyst with the Henry J. Kaiser Family Foundation and Patricia Neuman, vice president and director of the Medicare Policy Project at the Kaiser Family Foundation, more Medicare Part D plans will offer generic-only coverage to fill the "donut hole" gap in 2007 than did in 2006.

Under Part D in 2006, Medicare paid 75% of an enrollee's annual outpatient prescription drug costs between $250 and $2,250, 0% of the costs between $2,251 and $5,100 (the "donut hole"), and 95% of the costs over $5,100. However, private providers of Medicare prescription drug plans can structure their plans to fill the "donut hole" gap, so long as their overall prescription drug benefits are at least equivalent to Part D. Moreover, for low-income enrollees (i.e., with incomes less than 135% of the federal poverty level), Medicare fills the gap.

Cubanski and Neuman found that 48% of the 22.5 million Part D enrollees in 2006 had no coverage for the donut hole gap. Of the 52% with gap coverage, most were low-income enrollees whose coverage was paid by

Medicare. The authors predict that the number of private prescription drug plans with gap coverage will increase in 2007, but most of these will offer generic-only medications to fill the gap.

The authors also found that the majority of Part D enrollees were in stand-alone prescription drug plans rather than Medicare Advantage drug plans (72% compared with 28%). Moreover, most enrollees were concentrated in a small number of plans. Overall, 266 firms offered Medicare Part D coverage in 2006, with ten large health plans accounting for 72% of the Part D enrollment. In 2007, the number of national plans offering Part D coverage will expand from nine to 17 plans, with 31% more stand-alone PDPs available nationwide.

The researchers concluded that their findings will provide a basis for measuring Part D trends and future effects on medications, out-of-pocket spending, and overall health outcomes for Medicare beneficiaries.

The article is available for purchase on the Health Affairs web site at:
http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.1.w1

BCBSA Survey Indicates Consumers Want Quality Health Care Information

On November 28, 2006, the Blue Cross and Blue Shield Association (BCBSA) released a new research study, *Consumer Preference and Usage of Healthcare Information*, based on a survey of over 1,600 consumers, including those with BCBSA and non-BCBSA health insurance. The survey examined consumer preferences regarding health care information and decision-making factors for treatment options, hospital selection, primary care physician, and specialist choices. According to the study, consumers want information to support their health care decision making.

If diagnosed with a medical condition:

- 88% of consumers would search for information about treatment options;
- 81% would search for information about physicians or hospitals; and,
- 64% would obtain information from other sources in addition to their doctor.

Moreover, of those who made health care decisions in the past year, 64% researched information to select a physician, specialist, hospital, or treatment plan. However, the survey also indicates that consumers were unable to obtain quality clinical information, such as the percentage of patients who have received proper preventive care screenings and medications, mortality rates, complication rates, and comparisons with other providers.

According to Scott P. Serota, BCBSA president and CEO, "transparency in health care information is a growing trend and consumers want increased access to information so they can make the best decisions regarding their health care options." He added that it is critical to ensure that both quality of care and cost information are presented for an accurate assessment. In making health care decisions, Serota warned consumers that "cost does not equal quality."

The survey can be found at: http://www.bcbs.com/consumertransparency/ by clicking on the survey link.

EBRI Finds Consumer-Driven Plan Enrollment and Satisfaction Low

On December 7, 2006, the Employee Benefit Research Institute (EBRI) and the Commonwealth Fund released a study of consumer-driven health plans (CDHPs) published in EBRI's *Issue Brief* for December 2006. The study defined CDHPs as health insurance with high deductibles of $1,000 or more for individuals and $2,000 or more for families, combined with a health savings or health reimbursement account for medical expenses. Generally, the study found that enrollment in, and satisfaction with, CDHPs were very low compared with more comprehensive insurance.

According to the study, only 1% of privately insured Americans ages 21 to 64 (1.3 million) were enrolled in CDHPs in September 2006. Of those only 37% were very satisfied with their CDHP compared with 67% of those with comprehensive plans. In addition, the study found that enrollment in CDHPs has not significantly reduced the number of people without health insurance, as originally predicted. Moreover, those in CDHPs were more likely to postpone needed medical care. According to the study, 38% of those in CDHPs said they had delayed or avoided getting needed medical care compared with 19% of those enrolled in comprehensive insurance.

Karen Davis, president of Commonwealth Fund, was quoted by BNA's *Pension & Benefits Reporter* as saying: "Despite their tax advantages, consumer directed health plans are not attracting large numbers of adults without health coverage, relative to other insurance. New strategies are needed to provide affordable and meaningful insurance to the nation's 47 million uninsured."

The study is available at: http://www.ebri.org/pdf/briefspdf/EBRI_IB_12-20061.pdf

DOL Finds Alternative Investments Are Not Imprudent 'Per Se'

On December 7, 2006, Bradford P. Campbell, acting assistant secretary for the Department of Labor (DOL), was quoted at an American Institute of Certified Public Accountants conference as saying: "Alternative investments such as hedge funds are not 'per se' imprudent investments for pension plans." He also reported that the DOL recently responded to a letter from Senator Charles Grassley (R-IA), chairman of the U.S. Senate Finance Committee. Grassley had requested federal agencies with jurisdiction over hedge funds to provide information about current hedge fund transparency rules and make recommendations for ways to improve such transparency.

According to Campbell, in responding to Senator Grassley, the DOL referenced the Employee Retirement Income Security Act regarding fiduciary responsibilities, which provides that fiduciaries "have an obligation to invest solely in the interest of participants and beneficiaries, to invest prudently, and to invest diversely, so that plans are not exposed to large losses." Therefore, in evaluating investments, fiduciaries need information about the underlying securities and risks associated with investments in order to assess their appropriateness for the investment portfolio. "Within that framework, alternative investments … are not 'per se' imprudent."

Source: BNA *Pension & Benefits Reporter,* December 12, 2006.

District Court Rules 403(b) Annuity Is Not Exempt From Bankruptcy Estate

On October 31, 2006, the U.S. District Court for the Western District of Pennsylvania reversed a bankruptcy court opinion, finding that only trusts can be excluded from a debtor's bankruptcy estate and, therefore, a 403(b) annuity could not be excluded (*Skiba v. Plonski*, W.D. Pa., No. 05-150Erie, 10/31/06).

On January 12, 2004, the Plonski's filed a petition for bankruptcy under Chapter 13 of the Bankruptcy Code, later converted to Chapter 7. Among their holdings was a qualified § 403(b) annuity, a portion of which they claimed was excluded from the bankruptcy estate under Bankruptcy Code § 522(d)(5). The bankruptcy trustee objected, arguing that the annuity could not be excluded from the bankruptcy estate because it did not constitute a trust as required under Bankruptcy Code § 541(c)(2).

In deciding the case, the U.S. Bankruptcy Court for the Western District of Pennsylvania relied on its opinion in *Skiba v. Gould.* In *Gould*, the bankruptcy court turned to the U.S. Supreme Court's decision in *Patterson v. Shumate* and the dissenting opinion in the Sixth Circuit Court of Appeals of *In re Adams* to find that a pension plan did not have to qualify as a trust to be excluded under § 541(c)(2) and, therefore, denied the bankruptcy

trustee's objections. The trustee appealed, arguing that § 541(c)(2) must be read literally to require a trust before a pension could be excluded.

In reviewing the case, the U.S. District Court noted that *Gould* had been reversed on appeal and found that the Third Circuit Court of Appeals decision in *Orr v. Yuhas* was controlling. In *Yuhas*, the appellate court found that an individual retirement account (IRA) must be a trust under § 541(c)(2) to be excluded from a bankruptcy estate. The district court reversed the bankruptcy court's decision and remanded the case, concluding that "only a debtor's beneficial interest in a *trust* may be excluded from the bankruptcy estate pursuant to that subsection (§ 541(c)(2))."

Source: *Skiba v. Plonski*, W.D. Pa., No. 05-150Erie, 10/31/06.

Comment: *The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005, enacted on April 20, 2005, established new provisions related to bankruptcy protections for debtors' retirement funds. For bankruptcy cases begun after October 17, 2005, the Act provides a new federal exemption for retirement funds held in certain tax-favored plans or accounts. Section 224(a) or the Act adds a new exemption to Bankruptcy Code § 522 for "retirement funds to the extent that these funds are in a fund or account that is exempt from taxation under [Internal Revenue Code] section 401, 403, 408, 408A, 414, 457, or 501(a) of the Internal Revenue Code of 1986."*