An Overview of Health Care Reform and the BESTflex[SM] Plan

The recent health care reform legislation affects health care and employee benefit plans of all shapes and sizes. Employee Benefits Corporation wants to make sure that you're well aware of its impact on the BESTflex Plan.

Four provisions of the legislation directly affect the BESTflex Plan Health Care Flexible Spending Account (FSA). In this flyer, we'll address the immediate increase in the age of a dependent, the fast-approaching restriction of over-the-counter medicine coverage, the $2,500 cap on Health Care FSA elections in 2013, and the excise tax on high-cost health plans scheduled to take effect in 2018. We'll also provide information that may help you put the extent of these changes in perspective.

March 30, 2010: Expanded definition of "dependent"

Effective March 30, 2010, the definition of "dependent" for purposes of tax-free health coverage has been expanded to include adult children through the end of the calendar year in which they turn age 26. This means that BESTflex Plan participants can now receive tax-free reimbursements for a dependent through the end of the calendar year in which the dependent turns 26.

BESTflex Plan participants can submit claims, retroactive to March 30, 2010, for dependents who are now eligible. Moving forward, they may also increase their Health Care FSA election if this expansion causes a dependent to become eligible to receive tax-free reimbursements from the plan. Participants must make the election change during the month of May, 2010.

Because only the age changed in the dependent definition, your legal BESTflex Plan documents, including the Summary Plan Description and Plan Document, remain accurate.

January 1, 2011: Restriction on over-the-counter medicine coverage

Starting January 1, 2011, BESTflex Plan Health Care FSA participants will only be reimbursed for their over-the-counter (OTC) medicine expenses if they have a **prescription** – not just a doctor's letter recommending the treatment – for the medicine.

OTC medicines will be treated the same as prescription drugs in terms of reimbursement from the BESTflex Plan. While participants will not need a prescription to **purchase** the OTC medicine, they will need a prescription to be **reimbursed** for it.

Regardless of your plan year, this provision takes effect on January 1, 2011.

Should you be concerned about the OTC drug restriction hurting your BESTflex Plan?

Not necessarily. Industry statistics show that OTC medicine reimbursements account for less than five percent of total reimbursement payments from Health Care FSAs. Only about 33 percent of FSA-eligible items are OTC medicines.

Just as we saw no significant increase in participation and election amounts when the IRS allowed Health Care FSAs to cover OTC expenses in 2003, we do not expect any significant decrease with this change.

How does this affect participants whose plan year does not run according to the calendar year (e.g., July 1 to June 30)?

The effective date is January 1, 2011, regardless of the plan year. All participants in the BESTflex Plan Health Care FSA will need a prescription in order to be reimbursed for the OTC medicines they purchase on or after January 1, 2011.

Does the participant need to present the prescription at the pharmacy for the OTC medicine to be reimbursable?

No. The participant can submit the prescription with their reimbursement request or obtain and submit the prescription after we notify them that a prescription is required.

What effect does this have on other medical expenses?

The legislation only restricts OTC medicine – things like cough medicine, allergy medication, and aspirin. Medical expenses that are not drugs, such as contact lens solution, bandages, ice packs, heating pads, braces, and durable medical equipment, are unaffected.

How does this affect claims submitted during the 90-day runout period in 2011?

The 90-day runout period gives participants 90 days after the plan year ends to submit claims for the expenses they incurred during the plan year.

Any OTC medicine purchased in **2010** does not require a prescription. Therefore, for calendar-year plans, claims submitted during the next 90-day runout period (January 1, 2011 to March 31, 2011) will not require a prescription.

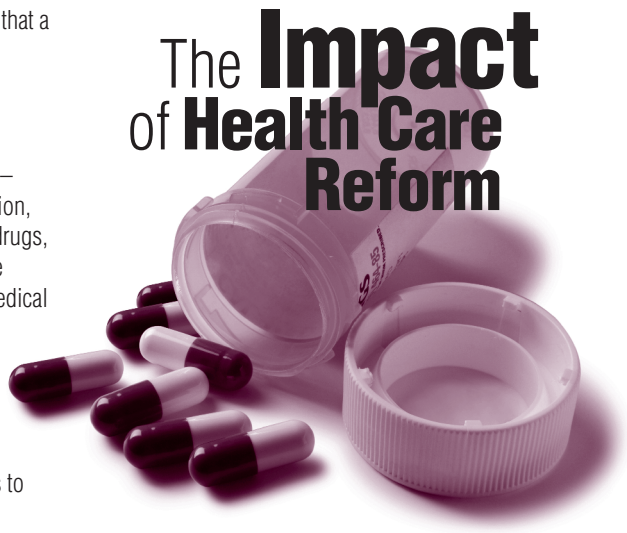
On the other hand, any OTC medicine purchased in **2011** requires a prescription for reimbursement. Therefore, for non-calendar year plans, claims submitted during the 90-day runout period will require a prescription based on the date the participant purchased the OTC medicine.

For example, assume an employer's plan begins on April 1, 2010. The 90-day runout period will then run from April 1, 2011 to June 30, 2011. Any OTC medicines purchased between April 1, 2010 and December 31, 2010, and submitted for reimbursement during the runout period will not need a prescription. Any OTC medicines purchased between January 1, 2011 and March 31, 2011, and submitted for reimbursement during the runout period will require a prescription for reimbursement.

How does this affect claims submitted during the 2-1/2 month grace period?

The 2-1/2 month grace period gives Health Care FSA participants an extra 2-1/2 months to use up their Health Care FSA balances.

Any 2-1/2 month grace period that extends into 2011 or begins in 2011 will be affected by the OTC limit. Any OTC medicine purchased on or after January 1, 2011 and submitted for reimbursement during the 2-1/2 month grace period will require a prescription.



EXAMPLE: 2012-2013 ONLY

$4,000 Election; Plan Year Runs from July 1, 2012 to June 30, 2013

2013 2014

$2,000 deducted July 1, 2012 to December 31, 2012	**$2,000** deducted January 1, 2013 to June 30, 2013	**$500** left to be deducted July 1, 2013 to December 31, 2013

The $2,500 cap, when it takes effect, can create an issue for plans that do not run according to the calendar year. Because the above participant could not choose to elect different amounts for the first and second half of the plan year (e.g., $500 and $2,000), the maximum pre-tax election for the plan year starting July 1, 2013 would be $1,000.

Example 1: Employer ABC renewed their plan November 1, 2009. Their 2-1/2 month grace period will run from November 1, 2010 to January 15, 2011. Any OTC medication purchased on or after January 1, 2011 will require a prescription to be reimbursed, even using the funds remaining from the previous plan year during the grace period.

Example 2: Employer XYZ renewed their plan January 1, 2010. The 2-1/2 month grace period will run from January 1, 2011 to March 15, 2011. Any OTC medication purchased during the grace period will require a prescription to be reimbursed.

January 1, 2013: $2,500 Cap on Health Care FSAs

The health care reform legislation creates an annual cap of $2,500 on pre-tax Health Care FSA deductions, adjustable for inflation. For plans that renew on January 1, 2013, the maximum, pre-tax Health Care FSA deduction will be $2,500.

Should BESTflex Plan clients be concerned about the $2,500 cap?

Employee Benefits Corporation's data says, "in many cases, no." The average, annual election for our BESTflex Plan Health Care FSA is currently $1,051, which is well below the $2,500 cap. Of course, some participants exceed that amount, and the cap will alter their elections starting in 2012 or 2013.

*How does the $2,500 cap affect BESTflex Plans that do **not** run according to the calendar year?*

The cap limits participants to a total pre-tax deduction of $2,500 **during the 2013 calendar year** (or tax year). For non-calendar year plans (e.g., a plan that runs from July 1, 2012 to June 30, 2013), participants with large elections starting in mid-2012 could be limited in 2013.

In the example at the top of this page, a participant makes a $4,000 Health Care FSA election for the July 1, 2012 to June 30, 2013 plan year. $2,000 is deducted from July 1, 2012 to December 31, 2012. The next $2,000 is deducted from January 1, 2013 to June 30, 2013.

This leaves $500 to be deducted on a pre-tax basis for the rest of 2013, keeping the participant within the $2,500 cap. He or she would be limited to a $1,000 pre-tax election for the full plan year. Any additional amounts would be subject to the normal payroll taxes.

There are a few things BESTflex Plan clients can do to avoid confusion regarding limited pre-tax deductions for plan years starting in 2013.

1. Employers can limit the maximum pre-tax election for their Health Care FSA to $2,500 starting a year early, in 2012
2. Employers can simply allow participants who go over the $2,500 to pay normal taxes on the excess amount
3. Employers can run a short plan year to get their plan on the calendar-year schedule by January 1, 2013

January 1, 2018: Excise tax on high-cost health plans

The health care reform legislation introduces a 40 percent excise tax that is scheduled to take effect in 2018. The excise tax seeks to urge health plans to reign in coverage costs for employees.

The excise tax is a tax on "excess benefits" provided under employer-sponsored health coverage.

"Excess benefits" refers to annual costs of coverage that exceed $10,200 for single coverage and $27,500 for family coverage.

These amounts include the employer's and employee's share of the cost of the coverage.

Notably, contributions to the BESTflex Plan Health Care FSA – in addition to benefits provided through a Health Reimbursement Arrangement (HRA) and Health Savings Accounts (HSA) – factor into the total, annual cost of coverage. For Health Care FSAs, the cost of coverage includes the employee's annual election and any employer contribution.

The excise tax for the Health Care FSA would be calculated in proportion to its contribution to the total cost of coverage. It would be Employee Benefits Corporation's responsibility, as the plan administrator, to pay the prorata portion of the excise tax attritutable to the Health Care FSA.

This is an overview of health care reform provisions that affect the BESTflex Plan. Employee Benefits Corporation will provide additional communications regarding health care reform to employers and participants in the coming months. Please contact your Client Liaison at **800 346 2126** if you'd like to discuss health care reform legislation as it relates to your BESTflex Plan.

The BESTflex℠ Plan

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