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- REPRESENTATIVES CHARLES BOUSTANY (R-LA) AND JOHN LARSON (D-CT) INTRODUCE FSA “CASH OUT” BILL

Recently, Representatives Charles Boustany (R-LA) and John Larson (D-CT) introduced a bill that would suspend “the use or lose it rule”, beginning in 2013, for Flexible Spending Accounts (FSAs) and allow people to “cash-out” their remaining balances at the end of the year, but pay taxes on them. The bill would also allow people with FSAs existing before passage of the bill 3 months to revise their contributions. According to Representatives Boustany and Larson, one quarter of FSA participants forfeit some of their funds each year.

IMPACT ON EMPLOYERS AND EMPLOYEES: Allowing employees to “cash out” their remaining FSA balances would increase the use of FSAs and the amounts people elect to put in them to help pay for their out-of-pocket medical expenses. Employers would be able to convince more employees to use FSAs to pay for their out-of-pocket medical expenses, but those who rely on leftover FSA balances to offset administrative and health plan costs would no longer be able to do so.

OUTLOOK: *House Republicans will likely include provisions to enhance health accounts and may include the FSA “cash out” bill when they introduce their own health care bill to “replace” the health care law. It is unclear if the Senate will consider the House’s “replace” bill, but the President is unlikely to sign it.*

BACKGROUND: Under current law and Internal Revenue Service (IRS) rules, people must spend their FSA balances by the end of the year or by March 15 of the next year if their employers adopt the 2 ½ month grace period or forfeit the money back to their employers under the “use-it-or-lose-it” rule.

The IRS does not allow employers to return employees’ FSA forfeitures or allocate the funds to them in a way that is directly or indirectly based on their unused FSA balances.

The IRS currently allows employers to use unused (forfeited) FSA funds in the following ways:

- Applying them toward "reasonable" administrative costs incurred during the plan year;
- Reducing the cost to all participants in the following year's FSA plan (employees who elected a \$1,000 account, for example, might pay only \$980);
- Donating them to a charity of their choice;
- Crediting forfeited amounts or "experience gains" to employees' FSAs in the following plan year, as long as the funds are allocated on a "reasonable and uniform" basis to all of the FSA plan participants; and
- Leaving the forfeitures in their bank accounts to fund the plan.

President Bush previously proposed to allow people to carry forward up to \$500 in unused balances in FSAs to the following year, to cash out and pay taxes, or to roll the funds over into 401(k), 403(b), and 457(b) plans.

The Tax Relief and Health Care Act of 2006 allows participants a one time rollover of their remaining FSA balances into Health Savings Accounts (HSAs) before December 31, 2011.

NATIONAL BUSINESS GROUP ON HEALTH VIEW AND ACTION ON THESE ISSUES: The Business Group supports allowing unused FSA dollars to remain in individuals' FSAs to meet future health care needs, or to roll them over into HSAs when that option is available. Eliminating the "use-it-or-lose-it" rule and adding a carry forward of FSA funds would ensure that FSAs become even more valuable to working Americans and their families and would ensure that individuals are not forced to use up or forfeit any remaining funds simply because their families' needs did not match their predicted annual health care expenses. Those who already use FSAs would find it even more attractive as a way to set aside money on a tax-deferred basis during the plan year and use these funds, as needed, to help pay for their out-of-pocket health care costs.

➤ SENATORS URGE PRESIDENT TO ACT ON ENTITLEMENT REFORM

With the country set to hit the debt ceiling between April 15th and May 31st, sixty-four Senators led by Michael Bennett (D-CO) and Mike Johanns (R-NE) recently wrote a [letter](#) to the President to act on entitlement changes (Medicare and Social Security), discretionary spending cuts and tax reform based on recommendations of the bipartisan [Fiscal Commission](#). The bipartisan letter follows an earlier [letter](#) from 23 Republican Senators, led by Senator Dan Coats (R-IN), urging the President to address entitlement reform because "unsustainable" federal expenditures on Social Security, Medicare and Medicaid are expected to double over the next decade.

The White House issued a statement agreeing with the bipartisan letter's goals, but without promising any specific action. Neither the White House, the Democratic-controlled Senate, nor the Republican-controlled House wants to be the first or the only party to propose cuts in entitlement spending.

The Congressional Budget Office (CBO) also released an updated [estimate](#) of the President's Budget this week that assumes that Medicare will run out of money in 2020

or 9 years earlier than previous estimates.

Senator Joe Manchin (D-WV) is the latest Senator to announce that he will not support another temporary federal government funding extension or raising the debt ceiling unless they are tied to significant cuts to the federal deficit. A number of Republican Senators including Senator Mike Lee (R-UT) are also calling to add a balanced-budget amendment to any future vote to raise the debt ceiling.

IMPACT ON EMPLOYERS AND EMPLOYEES: Congress and the President need to come to an agreement to reform our nation's expensive entitlement programs (Medicare and Social Security) and the state-federal Medicaid program to save the federal government from fiscal ruin and our economy too, before the Medicaid expansion begins in 2014, and both Medicare and Social Security run out of money, respectively in 2020 and 2037. The discretionary cuts in the 3-week extension only hit a small part of the larger federal budget and will have little impact on the federal government's public health programs. If Congress includes cuts for the implementation of the health care law in future government funding bills, it would only add to employers' and employees' uncertainty about whether the law will change in the future and the impact these potential changes will have on health care benefits.

OUTLOOK: *The President is waiting for the Senate to propose legislation addressing entitlement reform. A bipartisan "gang of six" including Senators Richard Durbin (D-IL), Kent Conrad (D-ND) and Mark Warner (D-VA), Mike Crapo (R-ID), Saxby Chambliss (R-GA) and Tom Coburn (R-OK) are working on a proposal to reform entitlements based on the Fiscal Commission's recommendations.*

Senate Republicans support a House-passed 7-month funding bill opposed by Senate Democrats that would cut an additional \$65 billion from 2010 spending levels and bar funding for the health care law. Senate Democrats and the White House will put forth their own proposal for a spending bill for the rest of the year.

BACKGROUND: The current U.S. debt owed by the federal government stands at \$13.5 trillion and rising. In January, the CBO raised its [estimate](#) for the annual deficit (spending more than it takes in on revenues) from \$1.1 trillion to \$1.5 trillion. Spending on the government's major mandatory health care programs—Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance subsidies to be provided through insurance exchanges in 2014—along with Social Security will increase from roughly 10% of Gross Domestic Product (GDP) in 2011 to about 16% over the next 25 years. Medicare, Medicaid, and SCHIP together account for 21% of total federal spending.

The bipartisan Fiscal Commission Co-Chairs released recommendations to balance the federal budget in November that included a number of items to shore up Social Security and Medicare, including:

- Taxing (fully or partially) employer-sponsored coverage (to finance Social Security);
- Expanding Medicare cost sharing and capping catastrophic costs;

- Identifying an additional \$200 billion savings in federal health spending from a variety of reforms that were included in the new health care law, such as expanding Medicare Accountable Care Organizations (ACOs), bundling Medicare provider payments, cutting Medicare Advantage payments;
- Setting a global target for total federal health expenditures after 2020 (Medicare, Medicaid, CHIP, exchange subsidies, employer health exclusion), and reviewing costs every 2 years (holding growth to GDP+1%); and
- Requiring the President to submit and the Congress to consider reforms to lower Medicare spending if costs have grown faster than targets (on average of previous 5 years), including: increasing Medicare premiums or cost-sharing; overhauling the Medicare fee-for-service system; developing a premium support system for Medicare; adding a “public plan” option and/or all-payer system in the exchange; or expanding the authority of the Independent Payment Advisory Board (IPAB).

NATIONAL BUSINESS GROUP ON HEALTH VIEW ON THESE ISSUES: The Business Group believes that we need a long term solution to the country’s unsustainable entitlement spending. We need to put our government’s fiscal house in order and invest in high value services and programs in order to strengthen our economy.

The Business Group supports maintaining the current tax treatment of employer-sponsored health coverage for over 176 million Americans, which helps make health care more affordable for employees, reduces the uninsured and keeps employer risk pools intact so employers can cover people of every age group and health status.

➤ CONGRESSIONAL REPUBLICANS QUESTION CLASS ACT

Last week, with a variety of actions, Republicans in Congress questioned the details of the Community Living Assistance Services and Support (CLASS) Act, part of the new health care law.

The House Energy and Commerce Committee held a hearing on the voluntary, employee-funded benefit that would allow employees to enroll in a program that, after 5 years of vesting, would pay disabled employees a benefit of about \$50 per day for non-medical services that help them remain in their homes and at work rather than be institutionalized. High premiums and funding issues have delayed the start of the program from 2011 to 2013. Health and Human Services (HHS) Assistant Secretary for Aging Kathy Greenlee, who is responsible for running the program, stated that HHS will not launch it unless it is financially sustainable and suggested indexing premiums for inflation so they would rise along with benefits. HHS Secretary Kathleen Sebelius reiterated this point at a separate Senate Finance Committee hearing where she also stated that HHS plans to raise the program’s low annual income requirement for eligibility (currently \$1,120) because [the Congressional Budget Office](#), [Medicare’s chief actuary](#), and [the American Academy of Actuaries](#) could not make it work without high premiums—currently about \$240 per month.

Meanwhile, Representatives Phil Gingrey (R-GA), M.D. and Charles Boustany (R-LA), M.D. introduced a bill that would repeal the CLASS Act. Representative Boustany also released a [study](#) by the nonpartisan Congressional Research Service (CRS) questioning HHS' authority to raise the income requirements beyond the amounts defined in the health care law.

Senator John Thune (R-SD) also sent a [letter](#) to Senate Budget Committee Chair Kent Conrad (D-ND) implying that HHS may have withheld actuarial models showing the problems with the CLASS Act before it became law and requesting a hearing on the program's solvency and sustainability.

IMPACT ON EMPLOYERS AND EMPLOYEES: The CLASS Act program is voluntary for both employers and employees. It would likely increase administrative costs for those employers who choose to participate in the program, but would enable some people to stay at work rather than quit because of disabilities or limitations in activities of daily living. While the program may help some employees pay for long-term care and stay at work, it could be very expensive for employees to pay into for years for benefits that, if they need them, are small.

OUTLOOK: *The House will likely pass a bill to repeal the CLASS Act, but it will encounter opposition from Democrats in the Senate and the President. HHS will move forward with changes to implement the CLASS Act program.*

BACKGROUND: The health care law creates a new national voluntary long-term care benefit program. To pay for the program, the federal government will deduct pre-tax premiums (initially set at \$65 per month at most, but as little as \$5 for those people with low-incomes) from the paychecks of employees who sign up for the benefit. The health care law also permits employers to auto-enroll employees as long as employees can opt-out. Employees could be eligible for benefits of \$50 per day, after paying into the program for at least 5 years, if they become unable to perform at least 2 or 3 activities of daily living (eating, toileting, transferring, bathing, dressing, and continence). They may use the money to purchase nonmedical services and supports they need to maintain independence at home and continue working. HHS will periodically adjust premium rates as necessary to assure solvency of the program for 75 years.

Participants can opt out during annual disenrollment periods established by the HHS Secretary and later re-enroll during open enrollment periods. The federal government will credit any prior payroll deductions on behalf of re-enrolling participants within 5 years.

HHS will also establish alternative enrollment procedures for employers who choose not to participate in the automatic enrollment process.

NATIONAL BUSINESS GROUP ON HEALTH VIEW ON THESE ISSUES: The Business Group believes it is important for employees to plan for the future and include the possible need for long-term care support services. However, it is uncertain whether the program, as designed, will be affordable and attractive to many employees and their families.

If you would like more details on these or other issues or would like a phone briefing on legislation, or want to express concerns about specific issues, please contact Steven

Wojcik, Vice President, Public Policy at wojcik@businessgrouphealth.org or 202-558-3012. **Also, as part of our "Ask a Benefits Question" service, we are happy to respond within 24 hours to any health benefits question on policy, regulations or legislation.**

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