As 2010 comes to a close, we become more entrenched in the rollout of health reform changes, including the 2011 prescription requirements for eligible over-the-counter (OTC) medicine expenses. Compliance Corner features clarification of recent IRS guidance related to OTC reimbursement and also includes a reminder for a fast-approaching cafeteria plan amendment deadline for adult child dependents, new Department of Labor COBRA subsidy resources, and HRA reporting requirements that began this month.

In News & Trends, find out why timely COBRA election and termination notices were crucial for a Louisiana employer faced with a lawsuit. We also spotlight recent research on COBRA subsidy participation rates as well as the outcome of a national survey focused on influencing factors for voluntary benefits selection. Finally, our COBRA expert, Ouida Peterson, explains when employers can pass on rate increases to COBRA participants.

Until next time, thanks for reading.

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IRS Clarification for Over-the-counter Drug Reimbursement

The IRS recently released Notice 2010-59 which clarifies new rules regarding the reimbursement of over-the-counter (OTC) medicines and drugs that were introduced in Section 9003 of the Patient Protection and Affordable Care Act of 2010 (PPACA). Beginning January 1, 2011, expenses incurred for medicines and drugs may be paid or reimbursed by an employer-sponsored accident and health plan, including health flexible spending accounts (FSA) and health reimbursement arrangements (HRA), only if the medicine or drug is prescribed by a physician (determined without regard to whether such drug is available without a prescription), or is insulin. (Note: These same rules apply to health savings accounts and Archer medical savings accounts, even though they are not employer-sponsored accident and health plans.)

For the purpose of OTC expenses, the IRS defines a prescription as “a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.” These rules do not apply to OTC health care-related items that are not medicines or drugs, including but not limited to equipment (e.g., crutches and other durable medical equipment), supplies (e.g., bandages and first aid kits), and diagnostic devices (e.g., blood sugar test kits and thermometers). These items may qualify for reimbursement under a health FSA or HRA if they otherwise meet the definition of medical care in Code Section 213(d). For a comprehensive list of eligible health FSA expenses, go to www.conexus.com/myfsa.
Substantiating an Expense
Notice 2010-59 clarifies that an OTC expense can be substantiated by submitting the prescription (or a copy of the prescription or other documentation that a prescription has been issued) for the OTC medicine or drug, and other information from an independent third party that satisfies the requirements under Prop. Treas. Reg. § 1.125-6(b)(3)(i). Acceptable documentation includes a pharmacy-issued customer receipt that identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase, and an Rx number. Receipts without an Rx number but accompanied by a copy of the related prescription are also acceptable.

Debit Cards and 90 Percent Pharmacies
Generally, health FSA and HRA debit cards, such as the CONEXIS Benefit Card, may not be used to purchase OTC drugs beginning January 1, 2011. However, the IRS has indicated that they will not challenge the use of debit cards to pay for OTC medicines or drugs through January 15, 2011, as long as the use of the card adheres to all other applicable rules for such use.

In addition, IRS rules allow health FSA and HRA debit cards to continue to be used to purchase OTC drugs at pharmacies that satisfy the 90 percent test in Notice 2007-2 until further guidance is issued. If a debit card is used in this manner, the participant must submit the required substantiation identified above.

However, as announced in June 2009, CONEXIS has chosen to prohibit the use of the CONEXIS Benefit Card at 90 percent pharmacies to ensure compliance for clients’ plans, limit risk and exposure, and provide a better user experience for participants by limiting potential declined transactions and substantiation requests. The CONEXIS Benefit Card may not be used to purchase OTC medicines and drugs, even if the pharmacy is a 90 percent pharmacy.

Effective Date
The prescription requirement applies to OTC medicines and drugs purchased on or after January 1, 2011. This effective date applies to all plans, regardless of the plan year dates. This means that the rules will change in the middle of the plan year for all plans that are not calendar year plans (i.e., a plan year that begins on January 1 and ends on December 31).

OTC drugs purchased in 2010 but submitted for reimbursement in 2011 (to the extent permitted) do not require a prescription. For health FSAs that offer a 2.5-month grace period feature, OTC drugs incurred in 2011 can be reimbursed from 2010 account balances only if the participant obtains a prescription as detailed above.

Plan Amendments
Notice 2010-59 has a special provision for plan amendments. Plan sponsors have until June 30, 2011 to make any plan document amendments required by these new rules. These amendments may be effective retroactively for expenses incurred after December 31, 2010 (or, with respect to debit cards, expenses incurred after January 15, 2011).

Additional Information

Fast-approaching Cafeteria Plan Deadline
As explained in IRS Notice 2010-38 announced earlier this year, cafeteria plans may permit employees to immediately make pre-tax salary reduction contributions for health benefits – including health FSAs – for adult children under age 26. This provision is allowable as long as the plan is amended no later than December 31, 2010, and the amendment is effective on the first date employees are permitted to make pre-tax contributions to cover children under age 26 (but not earlier than March 30, 2010).

COBRA Continuation Coverage Assistance under ARRA
The American Recovery and Reinvestment Act of 2009, as subsequently amended (ARRA), provides a COBRA premium reduction for eligible individuals who were involuntary terminated from employment between September 1, 2008 and May 31, 2010. However, this premium reduction is not available to individuals who involuntarily lost their jobs on or after June 1, 2010. For those who qualify for the COBRA premium reduction, they may continue to pay 35%
of the COBRA premium for up to 15 months as long as they are not eligible for other group health plan coverage or Medicare and remain otherwise eligible for COBRA continuation coverage. Please note: The Unemployment Compensation Extension Act signed by President Obama on July 22, 2010 did not extend the COBRA subsidy.

Subsidy Denials
Individuals who have been denied the COBRA subsidy can request review of their denial by the Department of Labor (DOL) or the Centers for Medicare & Medicaid Services (CMS). A determination will be issued within 15 business days. To request this review, individuals must complete and submit an application available at www.dol.gov/COBRA or http://www.continuationcoverage.net.

DOL Resources
The DOL recently issued a COBRA subsidy fact sheet and FAQs to provide guidance when an individual’s COBRA subsidy ends prior to the expiration of the maximum COBRA coverage period. These resources can help employers prepare for potential questions that may arise as former employees reach the 15-month maximum subsidy time allotment but before their respective COBRA coverage eligibility ends. Obtain the fact sheet at http://www.dol.gov/ebsa/newsroom/fsExpiringSubsidy.html and the FAQs at http://www.dol.gov/ebsa/faqs/faq-cobra-premiumreductionEE.html

HRA Reporting Requirements
On June 25, 2010, the Centers for Medicare & Medicaid Services (CMS) announced new reporting requirements for health reimbursement arrangements (HRAs). Known as the Section 111 reporting requirements, these new requirements are related to Medicare Secondary Payer Mandatory Reporting and mandate that a group health plan must pay claims as the “primary insurer” for an employee, or the employee’s spouse or dependent(s), if covered by both the plan and Medicare. New quarterly reports to CMS are also required.

Reporting Specifics and Penalties
HRA coverage must be reported by the “responsible reporting entity” (RRE); if CONEXIS is the third party administrator for your HRA, then CONEXIS is the RRE. Reporting is not retroactive and begins for plan years effective on or after October 1, 2010. HRAs with an annual benefit value of $1,000 or more must be reported, and those with totals less than $1,000 are exempt. RREs are required to report certain information related to “active covered individuals.” These are active employees, their spouses, or dependents who are eligible for Medicare and have group health plan coverage through an employer’s plan. Specific definitions and data criteria for active covered individuals can be obtained from the CMS Group Health Plan User Guide (linked below).

An RRE that does not comply with Section 111 reporting requirements will be subject to civil financial penalty equal to $1,000 for each day of noncompliance for each individual for which information should have been submitted. This penalty applies in addition to any other penalties prescribed by law and any Medicare secondary payer claim.

COBRA Election and Termination Notices Lawsuit
On July 16, 2010, the U.S. District Court in Shreveport, Louisiana ruled in favor of Psychiatric Services, Inc., an employer sued by a former employee who claimed her COBRA coverage was mistakenly terminated. The employer, which also was the health plan administrator, claimed that the former employee’s COBRA coverage was terminated because of her failure to pay COBRA premiums on time. The employee disputed that her payments were made as noted in the ambiguous notices and letters she received from her former employer, even though the election notice that she signed and dated informed her of COBRA eligibility and responsibility for timely payments.

After the former employee enrolled in the plan and paid her first COBRA premium, she was sent a letter that confirmed enrollment and noted a payment plan and due dates. When the next payment was missed, a courtesy letter was sent to the COBRA participant that stated payment was required (and postmarked by a specific date) to avoid losing COBRA coverage. When payment was not received, her COBRA coverage was terminated.

The district court found that the election notice was sent by the employer in a timely manner and contained essential information needed to inform the potential COBRA participant about COBRA enrollment and payment requirements. The former employee’s excuse that she did not open her mail in a timely fashion to read COBRA correspondence could not be the basis for finding that the employer did not give adequate notice.

Outsourcing the administration of your COBRA program not only reduces your workload and costs, but it also reduces your risk. CONEXIS images and electronically retains COBRA-related issued notices indefinitely. In addition, CONEXIS maintains, when necessary, hard copies of many types of COBRA correspondence. In the event of a dispute or litigation related to COBRA, these files are available to clients.

Influencing Voluntary Benefits Selection
Sun Life’s Employee Benefits Group released findings of a nationwide survey of employees who responded that the likelihood of using voluntary benefits in the near future was the most influential determinant when making their benefits choices. Employer funding also had a significant influence on benefit selection.

Employees were likely to elect the majority of benefits offered by employers. About half of the respondents chose six or more products, and a quarter of the respondents selected four or five products. As noted in Sun Life’s past research initiatives, this survey validated that employees value benefits more than salary increases.

Preferred Resources
Printed materials were employees’ preference for learning about their benefits (84%), followed by online information (68%), or in group meetings (58%); however, findings showed that employees do not spend much time reviewing benefit information regardless of the format in which details are presented. Employees who do take the time to review benefits during open enrollment are likely to purchase benefits. And when employees have benefits questions, more than one-third of respondents noted they would turn to their employers for additional benefits explanation, another third would prefer to seek help from the benefits provider, and the remainder would turn to family members or benefits brokers for assistance.

Additional Information
Sun Life’s survey included a pool of more than 2,800 adults who were the primary or shared decision maker for benefits selection in their households. Employees either worked full or part-time for an employer that had 25 or more employees. For additional information, go to http://sunliferesearch.com.
Research Shows Significant Increase during COBRA Subsidy

According to a recent study conducted by Hewitt Associates, the number of COBRA-eligible individuals who elected COBRA coverage was double the average 12% COBRA enrollment rate. COBRA-eligible employees who were involuntarily terminated and elected coverage at the reduced premium reached its highest point in June 2009 (46%) then leveled off in May 2010 (31%) – with the average monthly enrollment rate of 38%. Hewitt analyzed COBRA enrollment rates from 2004 through the end of the COBRA premium reduction program in May 2010 using data from 200 large U.S. companies representing approximately 8 million employees. To access this report, visit www.hewittassociates.com.

SCENARIO: A health insurance carrier has informed XYZ Company of an off-cycle rate increase that becomes effective on November 1, 2010, even though the employer’s plan began on May 1, 2010 and ends on April 30, 2011. The employer has two COBRA participants who began COBRA continuation coverage in June 2011. After receiving a mailed notice about the premium change from XYZ Company, one of the participants complains, stating that the employer cannot increase COBRA rates for 12 months.

QUESTION: Should the two COBRA participants’ monthly premiums increase, or does the employer have to pay the rate difference until the next plan year begins?

ANSWER: The COBRA law is very specific about COBRA premium rules, especially regarding limitations on rate changes. The law requires employers to establish a 12-month determination period (normally plan anniversary date to anniversary date) during which the rates cannot increase, except for changes in coverage, when it is clear the plan is charging less than the maximum permissible amount (i.e., less than 102% or, if permitted, 150% of the applicable premium) or the allowed increase from 102% to 150% for Social Security disability extensions. This determination period is the same for continuing participants – it is not determined by their specific COBRA start date. So, this is not to say the specific COBRA participants’ COBRA premium rates will remain the same for 12 months. The participants will be charged the applicable premium required for their coverage (the same required for active employees).

Here’s an example. The XYZ Company’s health plan anniversary date is May 1, 2010, and the employer’s 12-month determination period for all COBRA participants is May 1, 2010 to April 30, 2011 and then May 1, 2011 to April 30, 2012. Employees leaving a company and electing COBRA continuation coverage in January 2011 will pay the rate from the determination period of May 1, 2010 to April 30, 2011.

The COBRA participants in this example do not have a personal determination period of January 1, 2011 to December 31, 2012. No, no! If the rates increase on the next plan anniversary date, May 1, 2011, the rate
will increase for all COBRA participants – regardless of their COBRA enrollment date.

To say the COBRA participant has a 12-month rate guarantee is correct; however, it is not specific to the participant’s COBRA start date. It is the 12-month determination period of the employer’s plan.

The determination period is “computed and fixed” and the COBRA premium cannot be changed during the determination period except for the limited situations mentioned above. Again, this assumes the employer charges the maximum 102% or 150% premium. If charging less than the allowable amount, the employer is allowed to adjust rates to the maximum at any time during the determination period.

With this information in mind, let’s decide what XYZ Company should do. They are already charging their COBRA participants the maximum rate (102%) when their insurance carrier announces a fee increase in November. Since the rate increase occurs within the 12-month rate determination period and was not determined prior to the beginning of the determination period, the increase can’t be passed on to the participants, so XYZ Company will have to absorb the cost until the next rate determination period begins.

This quarter’s Reader’s Poll features a question about the new IRS regulations associated with health FSA plans. The real-time results are available at the end of the poll.

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