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REFORM Update

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The government recently issued two additional pieces of guidance to clarify certain health care reform requirements. The first piece helps employers, insurance carriers and third party administrators understand the over-the counter (OTC) medication exclusion as an eligible expense. The second piece of guidance was issued by the Department of Health and Human Services. This guidance discussed applying for a waiver to the limits on annual dollar maximums associated with essential benefits. The waiver process will interest employers who offer mini-medical plans or limited benefit plans.

This *Reform Update* reviews the specifics of the new guidance.

OTC Medications

Effective January 1, 2011, ***non-prescribed OTC medications*** will no longer be considered eligible expenses under employer-sponsored group health plans, medical flexible spending accounts, health reimbursement arrangements, health savings accounts and Archer medical saving accounts. The IRS has now clarified the process for administering this change.

IRS Notice 2010-59

The IRS will amend Sections 105, 106, 125, 220 (Archer MSAs), and 223 (Health Savings Accounts) of the Internal Revenue Code to redefine eligible medical expenses as they relate to OTC drugs. The new definition will be the same in each section of the Code and will be as follows:

Beginning after December 31, 2010, OTC medication expenses will be reimbursable only if the medication:

1. Requires a prescription.
2. Is available over the counter, but the patient obtains a prescription.
3. Is insulin.

To qualify for tax-favored status under HSAs and Archer MSAs, a non-prescribed OTC medication must be purchased before January 1, 2011. The accountholder can request a tax-favored distribution after January 1, 2011 (remember there is no claim submission process for HSAs) – as long as the drug was purchased before that date. If an employee uses HSA funds to pay for a non-prescribed OTC medication purchased on or after January 1, 2011, that amount will be taxable and the 20% excise penalty for using the funds for a non-qualified medical expense will apply.

Employers and third party administrators have had questions about how to verify claims for prescribed OTC medications. This notice answers those questions. It defines *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 the state." If a physician prescribes an OTC medication, for example, Zyrtec, the allergy medication, the employee can buy it at a local pharmacy and submit a claim along with a receipt and an Rx number.

If the pharmacy receipt includes the following information, it satisfies the substantiation requirements:

- The name of the purchaser or the name of the person to whom the prescription applies.
- The date.
- Amount of the purchase.
- An Rx number. (If an Rx number is not available, the employee can include a copy of the prescription.)

But what happens if the employee uses a debit card? Many employers offer debit cards to employees that have medical flexible spending accounts. A number of rules apply to using these cards. In some cases, the information collected when the employee uses the debit card is sufficient and the claim is automatically verified.

The concern is that the current debit card systems cannot recognize and verify that an OTC medication was prescribed. Therefore, the debit card cannot be used to buy OTC medications after January 1, 2011. However, the **IRS will not challenge** employees' debit card OTC medication purchases incurred through January 15, 2011, provided they satisfy the following requirements to verify the claim:

1. The employee has submitted either a copy of the prescription or a receipt with the Rx number.
2. The employee has supplied any other information the administrator requests.

As of January 16, 2011, a plan cannot reimburse expenses for prescribed OTC medications until the plan is able to substantiate the claims are actually for prescribed OTCs. This implies the debit card will no longer be able to be used to purchase these medications and the plan will have to revert to the manual process of submitting claims for reimbursement.

The government is hopeful that debit card vendors will modify their systems to collect more information at the point of purchase. At a minimum, the debit card vendor would need to collect the Rx number as part of the debit card process. Providing the government allows, this will permit vendors to again verify at the point of the point of purchase that the OTC medication indeed meets the requirements of "prescribed."

The restrictions apply only to OTC **medications**. Employees can still use the debit card to buy qualifying OTC items that are **not** drugs. The following over-the-counter items **are not** considered drugs and will still qualify:

- Medical equipment, such as crutches, braces, and so on.
- Medical supplies, such as bandages.
- Diagnostic devices, such as blood sugar kits.

Organizations will probably need to amend their cafeteria plans to reflect the changes in OTC medication eligibility and debit card requirements. This guidance gives employers until June 30, 2011, to adopt these amendments. As a general rule, amendments to the cafeteria plan are not permitted on a retroactive basis; however, in this case, the amendments can apply to expenses incurred after December 31, 2010.

IRS Revenue Ruling 2010-23

This ruling simply makes obsolete previous Revenue Rulings as to whether non-prescribed OTC medications are tax-favored. The obsolete Revenue Rulings include:

- Revenue Ruling 2003-102
- Revenue Ruling 2003-2, CB 559

This step was necessary to override the previously released guidance which is now irrelevant because of health care reform.

Annual Dollar Maximums Waiver Process

Health care reform restricts employers from establishing yearly dollar limits on coverage for essential benefits. As a result, some employers will have to increase or remove annual dollar maximums on prescription drug benefits or preventive care benefits, while others may be forced to eliminate their mini-medical plans. Mini-medical plans offer lower income, part-time, or seasonal employees limited benefits. Some employees choose a mini-medical plan because it is the only coverage available to them. In most cases, they are not eligible for comprehensive employer coverage.

When the government issued their initial guidance on the annual dollar restrictions, they did note the Secretary of the Department of Health and Human Services would issue a waiver process for plans that would likely need to eliminate coverage because the increase in benefits required to meet the health care reform requirements would result in such a sizable increase of premiums, that the employer would no longer be able to extend the coverage or employees could no longer afford the coverage.

Last week's DHHS *Insurance Standard Bulletin Series* discussed the waiver process. It explains that a waiver is available if compliance with the unreasonable annual dollar limits would result in a significant increase in premiums or would result in a significant decrease in benefits.

A group health plan or health insurance issuer may apply for a waiver to allow limited annual coverage maximums if the plan was available before September 23, 2010. The plan or policy year must begin between September 23, 2010, and September 23, 2011. The health plan must reapply for the waiver every year at least 30 days before the beginning of the plan year or policy year. If the plan or policy year begins before November 2, 2010, the health plan must apply for the waiver at least 10 days before the beginning of the plan year.

The waiver application must include:

1. The terms of the plan or policy forms.
2. The number of people covered.
3. The annual limits and rates to be waived.
4. A brief explanation (along with supporting documents) of why complying with the Interim Final Rules on removing annual maximum limits would cause either a significant decrease in benefits or a significant increase in premiums for currently covered employees.
5. The plan administrator's or Chief Executive Officer's signed statement certifying:
    a. The plan was in force before September 23, 2010.
    b. Removing annual maximum limits would cause a decrease in access or a significant increase premiums.

You can e-mail the application to healthinsurance@hhs.gov – (use *Waiver* as the subject line to make sure the e-mail is properly routed) or mail it to:

Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Office of Oversight
Attn: James Mayhew, Room 737-F-04
200 Independence Avenue, Southwest
Washington DC 20201

After it receives the information, DHHS will determine whether it can waive the unreasonable annual dollar maximum requirements. Remember you must resubmit the application annually to maintain the waiver until 2014.

Concluding Thoughts

Employers have been waiting for the answers to questions on covering prescribed over-the-counter medications and waiving restricted annual limits.

First, the newly issued government guidance defines a prescribed over-the-counter medication. Second, the guidance clarifies the process for using a debit card to buy a prescribed over-the-counter drug. The process for verifying claims is a bit complicated and definitely will change the process currently in use. Work with your third party administrator and your debit card vendor to understand the new process and explain it clearly to your employees.

At some point, your organization will need to amend your summary plan description to explain the changes in eligibility for covered over-the-counter prescriptions and the changes in the debit card process. At a minimum, your plan will need to advise employees prior to January 1, 2011, what steps need to be taken to cover prescribed OTC medications and advise that non-prescribed OTC medications are no longer an eligible medical expense under the plan.

Finally, if your organization offers a mini-med plan to certain employees and wants to continue offering that plan until 2014, you must apply for a waiver to allow annual maximum dollar limits. The good news is that the majority of these plans are fully insured, and it appears the insurance carrier can apply for the waiver for your plan. Check with your limited medical plan insurance carrier to determine how it will approach the waiver process.