McGraw Wentworth

REFORM Update

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Happy New Year! In 2011, McGraw Wentworth will continue issuing *Reform Updates* to keep your organization informed about the latest guidance impacting health care reform. A number of notices and bulletins were issued in December, 2010 to provide more details on various aspects of the legislation. This *Update* will review:

- An IRS notice which delays the effective date of nondiscrimination rules for fully insured health plans.
- Another IRS notice which modifies previous guidance on over-the-counter medications and the use of debit cards.
- Insurance Standards Guidance Series memo, discussing additional requirements for waivers of the annual restricted limits and the mini-medical plan market.
- A fifth installment of Frequently Asked Questions, addressing various aspects of health care reform.

Please remember that health care reform was addressed in two separate statutes passed in March, 2010: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. The most recent guidance conflates these two Acts as the "Affordable Care Act" or ACA. To be consistent, we will reference the Affordable Care Act or ACA when discussing health care reform.

IRS Notice 2011-1 - Section 105(h) Nondiscrimination Rules

The ACA basically extends the substantive requirements of the IRC Section 105(h) nondiscrimination requirements to fully insured plans. Fully insured plans will be subject to an excise penalty for failing to comply, generally $100 per day for each individual to whom the failure relates. In addition, a civil action can be levied for appropriate equitable relief.

The government requested public comments on the guidance needed to apply the nondiscrimination rules to fully insured plans. The comments received have raised fundamental concerns regarding compliance. **As a result, the Treasury Department, the IRS, the Department of Labor and the Department of Health and Human Services (referred to as the Departments) determined that insured plans will not be required to comply with the nondiscrimination rules until administrative guidance is issued.** In addition, the Departments anticipate that once such guidance is issued, it will not apply until plan years beginning after a specified time period. Sanctions for failure to comply with these rules will be delayed until that point.

Please note that this IRS Notice applies **only** to fully insured plans. Self-funded plans currently need to comply with the nondiscrimination requirements in order to offer tax-favored benefits to highly compensated employees.

IRS Notice 2011-5 – Over-the-Counter Medications and Debit Cards

The IRS recently released Notice 2011-5, amending an earlier notice that provided very limited opportunities for the use of debit cards when purchasing over-the-counter (OTC) medications. Remember, ACA revised the definition of eligible medical expenses under health plans, FSAs, HSAs and HRAs, and removed non-prescribed OTC medication as an eligible expense as of January 1, 2011.

This latest notice allows debit cards to be used when purchasing prescribed over-the-counter medications **after January 15, 2011**, as long as certain requirements are met. Debit cards can be used at drug stores, pharmacies, non-health care merchants that have pharmacies and with web-based or mail order pharmacy orders, if:

1. Prior to purchase:
    i. The prescription for the OTC medication is presented in any format to the pharmacist
    ii. The OTC medication or drug is dispensed by the pharmacist in accordance with the applicable law and regulations pertaining to the practice of pharmacy
    iii. An Rx number is assigned
2. In a manner meeting the recordkeeping requirements of the IRS, the pharmacy or other vendor retains a record of the Rx number, the name of the purchaser or the name of the person for whom the prescription applies, the date and the amount of the purchase.
3. All of these records are available to the employer or its agent upon request.
4. The debit card system will not accept a charge for an OTC medication or drug unless an Rx number has first been assigned.

If all these requirements are met, then the debit card transaction will be considered fully substantiated at the time and point of sale.

A more simplified process applies if a debit card is used to purchase prescribed OTC medications or drugs from vendors with a health care-related merchant code. In this case, only the following requirements must be met for the debit card transaction to be considered fully substantiated at the time and point of sale:

1. The pharmacy or other vendor retains a record of the Rx number.
2. The record of the Rx number is available to the employer or its agent upon request.

Remember, the debit card vendor manages the use of the debit card. You should discuss with your debit card vendor if they will allow employees to use the debit card in the above situations. **If so, your organization should let employees know what will be required to continue using the debit cards to purchase prescribed OTC drugs and medications.**

Insurance Standards Guidance Series Waivers of Annual Restricted Limits

The ACA allows only restricted annual dollar limits on essential benefits in 2011 through 2013, with annual dollar limits not permitted by 2014. This requirement affects employers' ability to offer limited benefit plans, sometimes referred to as mini-medical plans. Mini-medical plans are designed to provide limited benefits to employees who may be ineligible for comprehensive health benefits. Health plans may apply for a waiver of the annual restricted limits until 2014 to maintain limited benefit plans.

The plan needs to apply for a waiver and if the waiver is approved, it is effective for one year. The plan must reapply for the waiver in subsequent years. Initially, employers weren't able to implement a new limited benefits plan on or after September 23, 2010.

An Insurance Standards Guidance Bulletin issued by the Department of Health and Human Services (DHHS) in December, 2010 provided two modifications to the waiver process:

1. DHHS will allow very limited activity for the sales of new limited benefit plans after September 23, 2010. If a state has a mandate requiring specific carriers to offer these limited benefit plans, **only** these states can allow carriers to continue selling such policies to individuals or groups through September 23, 2011. DHHS is allowing this limited opportunity to continue selling these plans in order not to disrupt the current market in these states. These states can also apply for the waiver on behalf of the carriers that are required to offer these policies in accordance with a state mandate.
2. Based upon the latest grandfathering guidance, DHHS will permit employers to change limited benefit plan carriers in certain circumstance. Essentially, DHHS will allow an employer with a limited benefit plan, approved for a waiver, to switch to another carrier, also approved for a waiver, if the following requirements are met:
    a. In all cases, the plan sponsor must have been offering group health insurance, for which the issuer had obtained a waiver of the annual limit requirement from DHHS, since before September 23, 2010.
    b. The new insurer must have obtained a waiver from DHHS for the new policy.
    c. Except as permitted below, the annual limits of the new policy must not be lower than the annual limits of the previous policy.
    d. If an insurer is not offering the same coverage the plan sponsor had before September 23, 2010, then the plan sponsor may obtain a replacement policy with a lower annual limit only if other comparable coverage, with the same level of annual limits, is not available.

    The new health insurance carrier must obtain an attestation that the above criteria are satisfied from the group plan sponsor. The attestation must be accompanied by a copy of the prior policy outlining the terms of coverage. Insurance carriers are required to maintain these documents in accordance with the record retention rules of the waiver application.

Plans that are approved for waivers on the annual restricted limits are required to provide a notice to subscribers indicating the plan is not required to meet the annual restricted limits of the ACA. DHHS also released more details about this notice, which must include the dollar amount of the annual limit and a description of plan benefits to which the limit applies. The notice must be prominently displayed in conspicuous 14-point bold type in any informational materials, including plan and policy documents, which are provided to enrollees. A model notice is expected in the near future.

A number of plans have already been approved for a waiver on the annual restricted dollar limit requirements. However, please keep in mind that the waivers apply for only one year. This means that plans will need to reapply next year to maintain their waiver status.

Frequently Asked Questions

Over the last year, the Departments have published a series of Frequently Asked Questions (FAQs) to assist all stakeholders with implementation of the many aspects of health care reform. The fifth FAQ was published in December and can be found at http://www.dol.gov/ebsa/faqs/faq-aca5.html. The FAQs address health care reform issues, mental health parity and HIPAA's nondiscrimination rules as they relate to wellness plans.

Some of the issues of interest addressed include:

- One specific question notes a situation where a health plan does not impose a copayment for a colorectal cancer preventive service when performed in an in-network ambulatory surgery center. The plan will require a $250 copayment if the same service is provided in an in-network outpatient hospital setting. Is this plan design permitted under ACA? Yes, it is permitted because plans are permitted to use reasonable medical management techniques to control costs, which includes steering patients toward a particular high value setting for preventive care services. The plan, however, must accommodate any individuals for whom it would be medically inappropriate to obtain the preventive service in an ambulatory setting, by having a mechanism to waive the copayment required for an outpatient hospital setting if medically required.
- The FAQs confirm that the requirement to enroll new full-time employees automatically in the health plan, which applies to employers with more than 200 full-time employees, will not be in effect until administrative guidance is issued. The guidance is expected by 2014.
- There is a 60-day prospective notice requirement for material modifications to the plan or coverage. The FAQ confirms that this is tied to the new summary of benefits communication requirement, which will take effect within the next 18 months. Plans can expect to see a model notice from the government by March, 2011, and plans will need to deliver this notice no later than March, 2012. The 60-day prospective notice applies to any change in coverage or terms of the plan which are addressed in that summary of benefits.

- One question addresses a plan that determines out-of-pocket maximums based on a percentage of an employee's compensation. If the employee experiences an increase in the out-of-pocket maximum because of an increase in compensation, will this result in a loss of grandfathered status? As long as the employer does not make modifications to the formula to determine the out-of-pocket maximum, and the formula remains the same as was in effect on March 23, 2010, then the plan can maintain its grandfathered status.

Our next *Reform Update* will address the interim rules recently released to address the medical loss ratio requirements for health insurance carriers.