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Departments Issue New FAQs on Affordable Care Act

The U.S. Departments of Health and Human Services, Labor, and the Treasury on December 23, 2010, provided new frequently asked questions about the Patient Protection and Affordable Care Act and the Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

The first question involved a health plan that does not impose a co-payment for colorectal cancer preventive services when performed in an in-network ambulatory surgery center. The question asked if it would be permissible for the same preventive service provided at an in-network outpatient hospital setting to require a \$250 co-payment.

This plan design is permissible, the departments stated. Plans may use reasonable medical management techniques to steer patients toward a particular high-value setting such as an ambulatory care setting. But the plan should accommodate any individuals for whom it would be medically inappropriate to have the preventive service in the ambulatory setting by having a mechanism for waiving the otherwise applicable co-payment for the preventive service provided in a hospital.

In another question, the Department of Labor said employers are not required to comply with the automatic enrollment provisions of Section 18A of the Fair Labor Standards Act, until it issues regulations in this area. The department said it intends to complete its rulemaking by 2014.

Group health plans do not have to comply with the 60-day prior notice requirement for material modifications until plans and issuers are required to provide

the summary of benefits and coverage explanation according to standards issued by the departments, another question and answer stated. The departments have not yet issued the standards.

A group health plan that normally charges a co-payment for physician visits that do not constitute preventive services may charge this co-payment to individuals age 19 and older—including employees, spouses and dependent children—but waive it for those younger than 19, a question and answer stated.

One question involved grandfathered health plans. Suppose plan terms include out-of-pocket spending limits that are based on a formula—a fixed percentage of an employee's prior year compensation. If the formula stays the same but a change in earnings results in a change to the out-of-pocket limits such that the change exceeds the thresholds allowed under the interim final regulations relating to grandfathered health plans, will the plan relinquish grandfathered status? No. The departments have determined that if a plan or coverage has a fixed-amount cost-sharing requirement other than a co-payment, such as a deductible or out-of-pocket limit, that is based on a percentage of compensation formula, the cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan as long as the formula remains the same as that which was in effect on March 23, 2010.

Wellness Programs

A number of questions and answers addressed wellness programs. No employment-based wellness program is required to

check for compliance with the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination provisions. A wellness program is subject to the HIPAA nondiscrimination rules only if it is, or is part of, a group health plan.

It does not violate the HIPAA nondiscrimination regulations for a group health plan to give an annual premium discount of 50 percent of the cost of employee-only coverage to participants who adhere to a wellness program that consists of attending a monthly health seminar, a question and answer stated. The departments noted that the rule limiting the amount of the reward for health-contingent wellness programs to 20 percent of the cost of coverage applies only to programs that require satisfaction of standard related to a health factor to qualify for a reward.

Other examples of wellness programs that do not violate the HIPAA nondiscrimination regulations were provided. In one example, a group health plan gave an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The program consists of giving an annual cholesterol exam to participants. Participants who achieve a cholesterol count of 200 or lower receive the annual premium discount. Also, this plan provides that if it is unreasonably difficult or medically inadvisable to achieve the targeted cholesterol count within a 60-day period, the plan will make available a reasonable alternative standard that takes the relevant medical condition into account.

(cont'd on page 4)

IRS Issues Guidance on FSA and HRA Debit Cards for OTC Drugs

The Internal Revenue Service on December 23, 2010 issued **IRS Notice 2011-5** allowing the continued use of health flexible spending account (FSA) and health reimbursement arrangement (HRA) debit cards for the purchase of over-the-counter (OTC) medicines and drugs for which the taxpayer has obtained a prescription.

The guidance does not address health savings account (HSA) debit cards, in part because FSA and HRA purchases must be substantiated at the point of sale while HSA purchases are self-substantiated, with documentation saved by the purchaser and presented in the event of an IRS audit; inappropriate or “nonqualified” HSA distributions would then be subject to income tax plus a 20 percent penalty.

However, the accompanying frequently asked questions issued by the IRS note that under the Patient Protection and Affordable Care Act “only prescribed medicines or drugs...and insulin (even if purchased without a prescription) will be considered qualifying medical expenses and subject to preferred tax treatment” for FSAs, HRAs, and HSAs.

New Procedures

Effective January 16, 2011, in accordance with the guidance, the use of FSA and HRA debit cards to purchase OTC medications must comply with procedures reflecting those that pharmacies (as well as mail-order and web-based vendors) follow when selling prescribed medicines or drugs. These include requirements that:

- Prior to purchase, the prescription for the OTC medicine or drug is presented to the pharmacist or other authorized vendor.
- The OTC medicine or drug is dispensed in accordance with applicable law and regulations.
- The debit card system does not accept a charge for an OTC medicine or drug unless an RX number has been assigned.
- The pharmacy or other vendor retains a record of the prescription number, the name of the purchaser (or the name of the person for whom the prescription applies), and the date and amount of the purchase.

- All of these records are available to the employer or its agent on request.

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

In addition, the guidance clarifies that:

The prescription requirement applies to OTC medicine and drug purchases made on or after January 1, 2011, and not to purchases made in 2010 even if reimbursed after December 31, 2010.

(As noted above, January 16, 2010 is the date on which FSA and HRA debit card over-the-counter purchases must comply with all point of sale substantiation procedures).

The requirement applies only to OTC medications.

It does not apply to other health care expenses such as medical devices, eyeglasses and contact lenses.

Source: National Financial Partners

What is a Summary Annual Report and how does it need to be distributed?

Most employers are aware that an ERISA plan administrator must file an annual report (Form 5500) with the U.S. Department of Labor’s Employee Benefits Security Administration. Equally important for employers, however, is the requirement that an ERISA plan administrator provide covered participants and certain beneficiaries with an annual, narrative statement—called a summary annual report (SAR) - summarizing the material information contained in the plan’s Form 5500. A SAR is subject to certain content, notification and distribution rules under ERISA, and plan administrators may be liable for non-compliance to such rules.

Generally, if a plan is required to file a Form 5500, that plan’s administrator is also required to distribute a SAR to each plan participant and beneficiary. The SAR must be provided within nine

months of the close of the plan year or within two months after the close of any applicable extension period).

The SAR must contain a summary of the plan’s most recent Form 5500. While an exact determination of a SAR’s contents would be based on a particular plan’s most recent Form 5500, there are some general categories of content that will likely be included in a SAR, including: (1) funding and insurance information, (2) basic financial information (i.e., plan income and losses, investment earnings) and (3) participant’s rights to additional information.

As with a summary plan description, generally, the SAR must be distributed in a manner that is reasonably calculated to ensure actual receipt by plan participants. For all participants, the SAR may be sent by mail, hand-delivered or inserted in a company publication. It is not sufficient to post the SAR on the

Internet, intranet or bulletin board unless a separate notification informs participants of the location of the SAR, the significance of the document and a statement as to the right to request a paper version. For certain participants, the SAR may be sent electronically.

Although no specific penalty applies to a plan’s failure to distribute a SAR, participants and beneficiaries may bring suit to enforce any provision of ERISA. Also, criminal penalties of up to 10 years in prison and \$100,000 fine may be imposed for willful violations of any ERISA disclosure requirement.

Employers should consult their advisors to determine best practices with respect to SAR’s, including the specific content, notification and distribution rules discussed above.

Source: National Financial Partners

DOL Seeks Comments on Break Time for Nursing Mothers

The U.S. Department of Labor (DOL) on December 21, 2010, announced that it is seeking comments on provisions of the Fair Labor Standards Act (FLSA) that require employers to provide nursing mothers with reasonable break time and a private space for expressing breast milk while at work. The Patient Protection and Affordable Care Act amended the FLSA to add the requirement that employers provide breaks and private locations for nursing mothers.

The department noted that it does not plan to issue regulations implementing this provision at the present time.

“What the department is seeking to do is to develop guidance for employers that will assist them in complying with this new law and that will support women who choose to continue nursing once they return to work,” said Secretary of Labor Hilda Solis. “And with input from the Public—including working mothers and employers—we’ll be successful in doing that”.

The DOL noted in a Federal Register notice that the law requires space and time for unpaid breaks for one year after a child’s birth.

The frequency of breaks needed to express breast milk varies depending on such factors as the age of the baby. In a baby’s early months, the child may need as many as eight to 12 feedings per day, which means that a nursing baby needs food every two to three hours.

The DOL said it expects nursing mothers typically will need breaks to express milk two to three times during an eight hour shift. Usually when the baby reaches around six months of age, the frequency of nursing

decreases and the need for nursing mothers to take breaks gradually diminishes, it added.

Reasonable Break Time

The act of expressing breast milk typically takes about 15 to 20 minutes, but the DOL stated that other factors will determine a reasonable break time, including:

- The time it takes to walk to and from the lactation space and the wait, if any, to use the space.
- Whether the employee has to retrieve her pump and other supplies from another location.
- Whether the employee will need to unpack and set up her own pump or if a pump is provided for her.
- The efficiency of the pump.
- Whether there is a sink and running water nearby for an employee to use to wash her hands before pumping and to clean the pump attachments when she is done.
- The time it takes for the employee to store her milk in a refrigerator or insulated cooler.

The employer must ensure that there is a place at work where the employee can store the pump and insulated food container.

Employers are encouraged to discuss with nursing employees the location and availability of space for expressing milk, the DOL noted.

If it is not practicable for an employer to provide a room for nursing mothers, the requirement can be met by creating a space with partitions or curtains. The DOL sought comment on whether

and under what circumstances locker rooms could comply with the law.

The employer will not be considered to be in compliance if the designated space is so far from the employee’s work area as to make it impractical for the employee to take breaks to express milk, or where the number of nursing employees needing to use the space either prevents an employee from taking breaks or results in prolonged waiting time.

The space should have a place for a nursing mother to sit and flat surface other than the floor which to place the pump.

The DOL noted that some workplaces have limited space available to convert into a designated space to express breast milk. It sought comment on conditions where managers’ offices, storage spaces, utility closets and other spaces normally used for other purposes could be considered adequate spaces for use by nursing mothers.

It also sought comment on how employers can provide adequate break time and space for nursing employees who are not in a fixed place during a work shift, such as drivers, law enforcement officers and emergency medical technicians.

And the DOL sought comment on how employers can meet their obligations for nursing mothers who are working at other sites, such as at a client’s worksite. The DOL recommended that an employer arrange with a client to allow the employee to use a space at the client’s site.

Comments identify by RIN 1235-ZA00 may be mailed to Montaniel Navarro, U.S. Department of Labor, 200 Constitution Ave. NW, Room S-3502, Washington, D.C. 20210, or submitted through the Federal eRulemaking Portal at 222.regulations.gov. **Comments are due by February 22, 2011.**

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This wellness program does not violate the HIPAA nondiscrimination regulations because it satisfies the requirement of being available to all similarly situated individuals, the plan provides a reasonable alternative standard and the premium discount is limited to 20% of the cost of employee-only coverage.

In another example, a group health plan offers two different wellness programs, both of which are offered to all full-time employees enrolled in the plan. The first program requires participants to take a cholesterol test and provides a 20% premium discount for every individual with a cholesterol count under 200. The second program reimburses participants for the cost of a monthly membership to a fitness center. If someone participates in both wellness programs and receives both rewards, the plan is not violating the HIPAA nondiscrimination requirements. The first program must meet five criteria in the regulations, including the 20% limit on the amount of the reward. The second program is not based on an individual satisfying a standard that is related to a health factor, so it does not

have to satisfy the five criteria in the regulations.

The departments noted that they intend to propose regulations to raise the percentage for the maximum reward that can be provided under a health-contingent wellness program to 30 percent before 2014.

Mental Health Parity and Addiction Equity Act

Other questions and answers concerned the Mental Health Parity Act. Small employers are still exempt from the act's requirements. Although there were changes to the definition of "small employer" for other purposes under the Affordable Care Act, the Employee Retirement Income and Security Act and the Internal Revenue Code continue to define a small employer as one that has 50 or fewer employees. Accordingly, the departments will continue to treat group health plans of employers with 50 or fewer employees as exempt from the from the Mental Health parity and Addiction Equity Act.

Another question asked how a plan may claim an increased cost exemption. The exemption is available for plans that make changes to comply with the law and incur an increased cost of at least 2 percent in the first year that the law applies to the plan (the first plan year beginning after October 3, 2009) or at least 1 percent in any subsequent plan year (plan years beginning after October 3, 2010). If the cost is incurred, the plan is exempt for that plan year following the year the cost was incurred. A plan that has incurred an increased cost of 2 percent during its first year of compliance can obtain an exemption for the second plan year by following exemption procedures described in the departments' 1997 mental Health Parity Act regulations. Plans applying for an exemption must demonstrate that increases in costs are attributable directly to implementation of the law.

Source: Allen Smith, J.D. SHRM

IRS Delays Enforcement of Nondiscrimination Rules for Fully Insured Health Plans

The Internal Revenue Service on December 22, 2010, announced in Notice 2011-1 that compliance with the Patient Protection and Affordable Care Act's nondiscrimination rules for health insurance plans will be delayed until regulations or other administrative guidance has been issued. The IRS indicated that the guidance will not apply until plan years beginning a specified period after guidance is issued. The U.S. Department of Labor and U.S. Department of Health and Human Services have reviewed the notice and agreed with it.

The nondiscrimination requirement boils down to two mandates. First, a new, fully funded health plan cannot discriminate in favor of highly compensated individuals as to eligibility to participate; adherence to the requirement is determined by a numerical test. Second, a plan cannot discriminate in favor of participants who are highly compensated individuals as to benefits that are provided. The IRS noted that regulatory guidance is

essential to the operation of the nondiscrimination statutory provisions. The nondiscrimination requirements already apply to self-insured plans. Guidance will have to specify to what extent insured plans are subject to the same statutory provisions that apply to self-insured plans, the IRS noted.

Guidance must take into consideration the operation of state health insurance exchanges and individual and plan sponsor requirements that take effect after 2013, the IRS added.

Comments Sought

In the notice, the IRS sought comments on various issues, including:

The application of the nondiscrimination provisions to insured group health plans beginning in 2014 when the health insurance exchanges become operational and the employer responsibility provisions, the premium tax credit and the individual responsibility provisions are effective. The suggestion in previous comments that the nondiscrimination standards should be applied separately to employers

sponsoring insured group health plans in distinct geographic locations, and whether application of the standards on a geographic basis should be permissive or mandatory.

- The suggestion in previous comments that the guidance should provide for "safe harbor" plan designs.
- The application of the nondiscrimination rules to multiple employer plans.
- The treatment of employees who waive employer coverage voluntarily in favor of other coverage.
- Potential transition rules following a merger, acquisition or other corporate transaction.
- The application of sanctions for noncompliance with the nondiscrimination requirements.

Comments are due March 11, 2011. They should be submitted to Internal Revenue Service, CC:PA:LPD:RU (Notice 2011-1), Room 5203, PO Box 7604, Ben Franklin Station, Washington, DC 20224. Submissions may be sent electronically to otice.Comments@irs.counsel.treas.gov, and should include Notice 2011-1 in the subject line.