

K&P Benefits Insider

Timely information for the dynamic world of employee benefits

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IRS ISSUES HIGHLY ANTICIPATED GUIDANCE FOR HEALTH REIMBURSEMENT ARRANGEMENTS

On June 26, 2002 the IRS and Treasury Department released Revenue Ruling 2002-41 and IRS Notice 2002-45 regarding the favorable tax treatment of Health Reimbursement Arrangements (HRAs) permitting carryovers from one year to the next. An HRA is a type of defined contribution benefit plan that can qualify for tax exclusion under IRS Code Section 105. The rulings offer encouragement to many employers trying to find new and unique ways to design their employee benefit packages.

An HRA is defined as an arrangement funded by the employer and not funded by employee salary reductions under a cafeteria plan. The HRA can reimburse an employee up to a maximum amount for a coverage period and any unused amounts can be carried forward to the next coverage period. An HRA can reimburse the employee for substantiated medical care expenses (defined by Code Section 213(d)) incurred by the employee or employee's spouse and dependents, including premiums for accident or health insurance coverage. As a note of caution, individual policies purchased and reimbursed by an HRA can be treated as group health plan

coverage and may be subject to HIPAA and ERISA requirements. These issues are not addressed in this guidance. The Section 105(h) nondiscrimination rules for self insured-medical expense reimbursement plans apply to HRAs.

An HRA must be funded solely by the employer, and must not be attributable to employee salary reductions, even indirectly. An HRA cannot be part of a cafeteria plan, but an HRA can be offered alongside a cafeteria plan. For example, an employer can offer a high deductible health plan in conjunction with an HRA. The employer can sponsor a cafeteria plan that allows employees to pay for their share of the premium for the high deductible health plan through pre-tax salary reductions, but the maximum coverage for the HRA cannot directly or indirectly relate to the salary reduction amount elected under the cafeteria plan.

An employer can also offer an employee-funded Health Flexible Spending Arrangement (FSA) in conjunction with an HRA. A Section 125 Health FSA is subject to the "use it or lose it" rule; therefore employees should use any funds in the Health FSA prior to using the funds in the HRA. The issue in the

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Health Reimbursement Arrangements

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past has been that Section 125 states an expense may not be reimbursed under a health FSA if it has been reimbursed or is reimbursable under any other accident or health plan. In order to satisfy this requirement, the HRA plan document can now specify that coverage under the HRA is only available for expenses exceeding the dollar amount of the Health FSA coverage. Therefore, the Health FSA would be used first, and any remaining expenses would be reimbursed by the HRA. Employees cannot be reimbursed for the same expenses under both plans.

Since an HRA is paid for solely by the employer, any unused dollar amount remaining in an HRA at the end of a coverage period can be carried over to the next coverage period. An HRA, unlike a Health FSA, is not required to have a twelve-month coverage period and is not subject to the requirement that

the maximum amount of reimbursement be made available at all times during the coverage period. Claims incurred during one period of coverage can be reimbursed in a later period of coverage if the employee was covered by the HRA when the claim was incurred.

In order for reimbursements under the HRA to be a non-taxable benefit, no cash-out options or similar arrangements can be made available. For example, an employee cannot opt out of the HRA and receive the cash as taxable income. Also, if an employee terminates employment or retires, a bonus or severance payment cannot relate to that employee's remaining HRA amount.

HRAs are subject to COBRA continuation requirements. If an individual elects COBRA, the employer must make available the maximum reimbursement amount available at the time of the

individual's qualifying event and also must increase the maximum at the same time and by the same amount that it is increased for similarly situated active employees. Former or retired employees may continue to be reimbursed from an HRA for medical expenses incurred after their termination of employment, even if they do not elect COBRA. The employer may also add additional funds to an employee's HRA upon termination of employment or retirement as part of a severance package.

This recent guidance will provide employers with new and exciting options to combat the rapidly rising costs of providing comprehensive health care benefits for their employees.

Copies of the Revenue Ruling 2002-41 and IRS Notice 2002-45 can be found at <http://www.ustreas.gov/press/releases/po3204.htm>

Proposed Generic Drug Law

New legislation is being proposed in the U.S. Senate that would overhaul the current drug patent law. This new legislation is designed to eliminate tactics being used by brand-name drug companies to extend patents on highly profitable brand-name drugs and delay the more affordable generic versions.

The legislation would address the following issues:

- The bill would stop the filing of frivolous citizen petitions with the FDA designed to delay generic drug approval. Some of the petitions are filed and later dismissed without merit.
- Elimination of FDA delay of generic approval due to brand-name company claims that the color or shape of a pill resembles a brand-name drug.

- Prevent brand-name companies from delaying approval of generic drugs by challenging the equivalence of generic products. The FDA will only approve a generic drug if there is no significant difference to the brand-name drug.

- Prevent generic companies from delaying the marketing of competing products by failing to bring a drug to market. Currently, the first company to file a generic drug has exclusive rights regardless if they bring the drug to market or not.

Drug manufacturers claim the new legislation will eliminate protection of intellectual property and therefore discourage the creation of new drugs.

However, a recent study by the

Congressional Budget Office estimates that wider use of generic drugs could reduce drug costs of Americans by \$8 to \$10 billion dollars per year.

COBRA Correction

The Spring issue of the *K&P Benefits Insider* reported that when a COBRA qualifying event occurs, employers have "30 days to directly notify all qualified beneficiaries of their continuation of coverage rights". Employers, however, should notify all qualified beneficiaries within 14 days of the qualifying event.

For more information, feel free to contact the Kibble & Prentice Tech Team or your Kibble & Prentice representative.

Cockle Decision

In January 2001, a decision in the *Cockle v. Department of Labor and Industries* case held that employer-provided health benefits must be considered part of the worker's earning capacity at the time of injury. The court ruled that health benefits represent part of the worker's earnings and could be readily identified and calculated. The time-loss compensation calculation must include:

- Pre-tax earnings
- Bonuses
- Tips
- Value of any room, board, housing or fuel provided to the worker
- Employer paid health care benefits for the worker and family

The 'Cockle Decision', as it is commonly referred to, states that the compensation benefit may be 60% to 75% of a gross wage up to the maximum monthly benefit, which is based on the state's average wage. The benefit amount also depends on marital status and

number of dependents.

The Department of Labor and Industries was given a one-time appropriation of \$2,900,000 to implement the new ruling regarding the calculation of workers' compensation benefits. As a part of the appropriation, the Department was asked to develop and report to the legislature proposed statutory language to make the calculations more clear and simple.

After further study, the Department recommended to simplify the wage calculations by paying a flat rate of 67% of gross wages. The gross wages would not include items such as medical premiums paid by the employer. The effect of the flat rate, versus the 60% to 75% used in the current system, will increase costs for time loss by \$18 million in 2002 with 17.3% of employees receiving a higher rate of pay.

The Department presented this recommendation to the legislature. No action has been taken at this time.

Expansion of Washington's Family Care Act

New legislation expanding Washington State's Family Care Act went into effect March 29, 2002. According to the current law, employees can use accrued sick leave to take care of themselves or their sick children under age 18.

Under the new legislation, employees can use sick leave, paid time off or vacation time to care for:

- Children with a health condition that requires treatment or supervision; or
- A spouse, parent, parent-in-law or grandparent with a serious health condition.

In keeping with the current standards, the new legislation does not allow employees to take time off before it is earned. Employees are required to adhere to the employer's existing leave policies except with regard to how the leave is used. If an employer requires prior notification or has a waiting period for new hires, these policies must be observed under the new legislation.

The new legislation forbids employers from retaliating against employees using leave in conjunction with this law. Employer retaliation consists of the following actions: discharging, threatening, demoting, suspending, disciplining or discrimination.

Washington's Family Care Act is designed to protect employees' rights not protected under FMLA. FMLA allows employee up to 12 weeks per year of unpaid leave to care for a seriously ill spouse, child or parent or for the employee's own serious health condition. However, FMLA does not address if paid leave can be used to care for a sick family member.

Although the legislature made it clear these amendments do not apply to short- or long-term disability plans, no mention of their exclusion is included in the legislation.

Mental Health Parity

President Bush recently called for legislation to improve access to mental health care for employers of 50 or more employees. Most health plans do not provide equal care for mental health conditions compared to physical conditions.

Under the current mental health parity law, health plans must offer the comparable annual and lifetime maximums, but limitations may be placed on hospital stays or outpatient visits.

The General Accounting Office (GAO) recently conducted a survey showing 86% of responding employers comply with the current law but limit the benefit with day or visit limits.

Proponents of the legislation say mental health is a serious problem for Americans with many people going undiagnosed and untreated. The federal government recently estimated there are 20 million Americans with a diagnosable mental illness.

Opponents of the proposed legislation are concerned about the impact of the law to health plan costs that have been spiraling out of control over the last few years. According to one source, mental health benefits average 3-4% of plan costs, but this new benefit will increase cost by another 1%. Under the current law, employers are not required to comply with the law if the new benefit increase plan costs by more than 1%.

Carrier Updates

First Choice Health Plan

The First Choice Health Plan (FCHP) will be terminating effective January 1, 2004. Effective immediately, FCHP will no longer underwrite health insurance on a direct basis. Current clients will be able to maintain the Plan until the January 1, 2004 termination date. The First Choice Health Network will continue to be offered only through third party administrators and association plans.

Premera Blue Cross

In February 2002, United Anesthesia cancelled their contract with Independence Blue Cross. United Anesthesia provided almost all of the anesthesia services for the Main Line Health System Hospitals in Pennsylvania. Effective March 6, 2002 an agreement was completed with United Anesthesia to contract with Independence Blue Cross.

Three major pharmacies in the Seattle, WA area have re-signed with Premera Blue Cross: Harborview Pharmacy, University of Washington and Evergreen Pharmacy.

The Radiology Associates of Lewis County, Inc. P.S., serving Providence Hospital, Morton Hospital and Steck Medical Center, are no longer a part of the Premera Blue Cross participating, preferred and HealthPlus networks. The three providers will be directing Premera members to other radiology facilities.

Effective April 10, 2002 Merck-Medco Home Delivery will discontinue dispensing the acne medicine Accutane due to stricter requirements by the FDA and the manufacturer of Accutane. Merck-Medco will be notifying members who have received Accutane through Home Delivery in the last six months.

The Surgical Specialists of

Yakima have signed a contract to participate in the Premera Blue Cross provider network. Effective June 1, 2002 members may receive care at the Surgical Specialists of Yakima and receive the highest level of reimbursement. This applies to the Prudent Buyer (Preferred), Participating and HealthPlus Premera Blue Cross plans and the Preferred and Traditional MSC/ Premera Blue Cross plans.

On June 1, 2002 the brands for Eastern and Western Washington were consolidated under the legal name of Premera Blue Cross. MSC/ Premera Blue Cross will no longer be used for Eastern Washington. Also, beginning June 1, 2002 the brands for Washington and Alaska were consolidated. Premera Blue Cross Blue Shield of Alaska will now be used instead of Blue Cross Blue Shield of Alaska, a Premera Health Plan.

Alternare will administer the Premera Blue Cross chiropractic network effective September 1, 2002. Alternare currently administers the Complementary Alternative Network (CAM) for Premera. Alternare will contact providers in the current chiropractic network. The providers will need to re-contract with Alternare in order to remain in the network.

Premera released group contract changes effective for all new groups enrolling on or after July 1, 2002 and upon renewal for existing groups beginning July 1, 2002.

Medical Benefit Changes

- Dependent children are now eligible to remain covered under the plan until age 25.
- Private hospital rooms will be a covered benefit when the member's provider determines it to be medically necessary.
- The BlueCard program has been

expanded and now has contracted providers in Jamaica and the British Virgin Islands.

- The two-lens limit for contact lens purchases during a given benefit period has been removed. Now, any number of lenses can be purchased until the maximum dollar amount has been paid. This applies only to contracts that include a Vision Hardware benefit.

Dental Benefit Changes

- Dependent children are now eligible to remain covered under the plan until age 25.
- General anesthesia will be a covered benefit when necessary for enrollees under age seven or for enrollees with a physical or developmental disability.
- It is recommended that an estimate of dental benefits be submitted for services of \$1,000 or greater. This is an increase from the previous amount of \$300.

Rave Reviews for the Benefit Resource Center

Kibble & Prentice recently completed a random client service survey of employees who contacted a Benefit Specialist in the Kibble & Prentice Benefit Resource Center (BRC). The overwhelmingly positive results were based on the responses of 16 participants.

All of the participants indicated that the Benefit Specialist responded to their inquiry in a timely manner and 15 of the participants thought the Benefit Specialist was helpful. On a scale of 1-5, 1 being not satisfied and 5 being very satisfied, the average rating for the BRC was a 4.4. When the same question was asked about the satisfaction with the insurance carriers, the average rating was 2.8.

The Department of Labor (DOL) will be expanding the rules regarding electronic reporting applicable to employee benefit plans. The DOL's goal is to modify and expand the safe harbors available for electronic communication. The changes become effective October 9, 2002.

The intent of the change is to allow receipt of this information by individuals who may work from home or who are away for travel. The DOL feels that documents required to be delivered to employees should not only be available to employees at a common area in the workplace.

The new rules will allow electronic communication for two categories of individuals. The first category will be individuals who "have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform his or her duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties." The second category of individuals eligible to receive information electronically are participants, beneficiaries, and other persons entitled to disclosure documents under Title I of ERISA who consent to receiving documents electronically.

Since the new rules makes documents available outside of the workplace, the DOL has placed conditions on electronic communications to ensure adequacy. One requirement is any individual who chooses to receive documents through the internet or other forms of electronic communication must provide an address for receipt and must "consent or confirm electronically" to show the individual's ability to access the information. The DOL is also requiring that individual receive, prior to consent, a clear statement containing the following information:

- identification of the documents or types of documents to which the consent applies;
- explanation that consent may be withdrawn at any time and the procedures for withdrawal and changes of address;
- explanation of the individual's right to receive and process by which they may receive a paper copy of the document being provided electronically; and
- identification of any software or hardware requirements for receipt of this electronic information.

Under the initial proposal only Summary Plan Descriptions (SPDs), SPD summaries and summary annual reports were to be covered by the safe harbor. The final rule will permit all documents to be furnished or made available under Title I of ERISA included in the final safe harbor. The ruling however does not include communications such as those from the participants or beneficiaries to the plan or between the plan and the employer.

To be considered in compliance, employers will have to utilize a system that protects confidentiality. The system must preclude unauthorized access to or receipt of the information.

Contact the Kibble & Prentice Employee Benefits Tech Team

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The K&P Benefits Insider editors and writers are Aaron Rubardt, Patrick Rosenberry, Nikolai Brown and Carrie Liska.

They can be reached at 206-441-6300 or 800-767-0650. You may also contact them via e-mail at techteam@kpc.com.

Ideas??

If you have questions or ideas for future issues of the [K&P Benefits Insider](#) we would like to hear from you! Please call or e-mail us at techteam@kpc.com.

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Kibble & Prentice

600 Stewart Street, Suite 1000

Seattle, WA 98101

Phone: 206-441-6300 or
800-767-0650

www.kpc.com