K&P Benefits Insider

Timely information for the dynamic world of employee benefits

A newsletter presented by the Employee Benefits Division of Kibble & Prentice

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Debit Cards Approved for FSAs and HRAs

On May 6, 2003, the IRS issued Revenue Ruling 2003-43, approving the use of debit and credit cards for the reimbursement of qualified medical expenses from flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs). While debit cards are an attractive benefit, there are several key issues to keep in mind when implementing a program.

All expenses (except for copays, recurring amounts or expenses substantiated at the point of sale by fax, e-mail or phone) still require substantiation prior to reimbursement. The ruling makes it clear that the IRS will not consider a random sampling of expenses adequate substantiation. If a debit card is used to pay for an expense that is determined ineligible, the money must be recouped from the participant.

With the exception of payments to pharmacies for prescription drugs, employers are required to issue an IRS Form 1099 to all health care providers who receive payment by debit card, leading to additional administrative expenses. Some employers may choose to pass these costs on to plan participants.

Ruling 2003-43 is posted at http://www.irs.gov/pub/irs-drop/rr-03-43.pdf.

More information on the use of debit cards for FSA and HRA administration will be coming soon. Stay tuned!

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Medicare Drug Coverage

Both the House and Senate are considering bills that would add a prescription drug benefit to Medicare. Through the Social Security Administration (SSA), Medicare provides health insurance to people age 65 and older, certain disabled people under age 65, and people of any age who have permanent kidney failure.

Although Medicare does not cover all medical expenses, it assists with the cost of basic health care. Part A (free unless an individual did not work enough quarters before reaching age 65) covers inpatient hospital care, skilled nursing facility care after a hospital stay, home health care by a home health agency and hospice care. Part B covers outpatient and physician expenses and a number of other medical services and supplies. Most Medicare beneficiaries pay $58.70 per month for coverage.

Under the Senate bill, a Medicare beneficiary pays a monthly premium of $35, an annual deductible of $275 and 50% of the cost of drugs up to $4,500 a year. At that point, coverage stops and the beneficiary is responsible for the next $1,300 of drug costs. Coverage resumes at $5,800 with Medicare covering 90% of the costs.

For a $41 monthly premium, the House bill features an annual deductible of $250 and 20% coinsurance, up to $2,000 a year. Coverage then ceases until expenses reach $4,900; at that point, Medicare would pay 100% of drug expenses. The House bill provides additional subsidies to beneficiaries with incomes below 150% of the poverty level.

The proposed legislation is expected to cost more than $400 billion over the next 10 years and provide coverage to as many as 37 million seniors through traditional fee-for-service Medicare coverage or private plans. The private plans will be supervised by a new federal agency. Beneficiaries can choose to stay with the traditional Medicare plan and purchase drug coverage through private insurers offering "drug only" plans (which are not currently available). If less than two private plans enter a geographic market, then the government will step in to offer a "fallback plan."

There are many concerns about the proposed legislation, including:

- The potential for further reductions to private retiree health benefits. In recent years, employers have reduced or cancelled retiree coverage because of rising costs. The Congressional Budget Office projects 37% of retirees with employer-sponsored coverage will lose it if the legislation is passed.
- The growth of the senior population. Over the next 30 years, the number of Americans over 65 will increase from 37 million to 70 million.
- Rapidly increasing drug costs. Prescription drug spending has increased 15-20% a year for the past several years. The Congressional Budget Office projects the bill for Medicare, Medicaid and Social Security will equal 14% of the economy by the year 2030. Today the entire federal government budget is 20% of the economy.
- Potential out-of-pocket costs due to a lack of a hold-harmless agreement. Insurers and health plans would negotiate prices with drug companies. The government would calculate "the average negotiated price" for each drug dispensed to Medicare beneficiaries each year. Medicare could refuse to pay costs exceeding the average.

When the House-Senate Medicare conference committee met with President Bush on July 23, they promised a compromise between the two bills this fall.

Copies of the two bills are posted at the following addresses:

House - http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:h1rds.txt.pdf

Senate - http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_bills&docid=f:s1es.txt.pdf

New Proposed COBRA Notice and Disclosure Requirements!

On May 28, 2003 the Department of Labor (DOL) issued proposed COBRA regulations that clarify several notice and disclosure requirements and provide a sample initial notice (named "General Notice" by the DOL) and COBRA election notice. The regulations also include two new notice requirements for plan administrators. If approved, the new regulations will go into effect for plan years beginning on or after January 1, 2004.

Key highlights:

1. Employers must provide the General Notice to covered employees and spouses within the first 90 days following the commencement of coverage. An employer may send a single notice to both the employee and spouse if they reside at the same address. If a spouse becomes covered on a later date, the employer must send a separate notice to the spouse within 90 days after the coverage begins.
2. Covered employees and qualified beneficiaries are generally required to notify the plan administrator of certain qualifying events within 60 days. These events include divorce, legal separation, a dependent child ceasing to be a dependent, the covered employee's death or entitlement to Medicare, and a qualified beneficiary's disability determination. The plan must establish "reasonable procedures" for employees and qualified beneficiaries to provide this notice to plan administrators. The procedures should include the necessary content of the notice, to whom and where notice should be given and in what form. The procedures should be included in the General Notice and the Summary Plan Description.
3. Employers must notify plan administrators within 30 days following a qualifying event. Plan administrators are given 14 days from receiving the notice to provide the COBRA election notice to a qualified beneficiary. If an employer also serves as plan administrator, the proposed regulations clarify that an employer has a total of 44 days to provide the COBRA election notice following a qualifying event.
4. The DOL provided a model General Notice and election notice. Use of these model notices (appropriately adjusted to the employer's specific circumstances) provides plan administrators with a safe harbor. If the model notices are not used, the DOL has provided an outline of the necessary items that must be included in each notice. One important new requirement is information on the Trade Act of 2002. This establishes a second 60-day election period for certain individuals who become eligible for trade adjustment assistance.
5. New notice requirement – "Notice of Unavailability of COBRA Coverage." This notice must be sent within 14 days if an individual notifies the plan administrator of a qualifying event, but is not entitled to elect continuation of coverage. The notice must include a reason why the individual is ineligible.
6. New notice requirement – "Notice of Early Termination of COBRA Coverage." This notice must be sent to qualified beneficiaries "as soon as practicable following the administrator's determination that continuation coverage shall terminate" if COBRA is being terminated prior to the end of the maximum coverage period. This notice must include why and when the coverage was terminated and can be combined with the required HIPAA Certificate when group health coverage is terminated.

Since COBRA was enacted almost 17 years ago, this is the first time the DOL has issued proposed regulations with regard to notice and disclosure requirements. While these new regulations provide additional guidance and safe harbors that are beneficial, they will also create additional expenses and administrative efforts for employers and plan administrators.

These regulations have not been approved. The deadline for public comment has passed.

A copy of the proposed regulations is posted at www.dol.gov/ebsa/regs/fedreg/proposed/2003013057.pdf.

Carrier Updates

Aetna

- Beginning November 2003, new member ID cards for PPO medical and dental plans will display unique member numbers instead of Social Security numbers. Aetna will reissue ID cards for existing members when there is a business need (i.e., change to benefits). As of January 1, 2003, Aetna had revised most member documents to exclude S.S. numbers.
- Effective April 1, 2003, HMO and PPO plan contracts are returning to a base infertility benefit that covers diagnosis and treatment of the underlying medical cause.

CIGNA

- Through an alliance with SHPS, CIGNA now offers an employee leave program called "CIGNA Leave Solutions." The product enables management of federal and state Family and Medical Leave Acts, military leaves and other workplace leaves. The service, offered in conjunction with CIGNA's short-term disability plan, includes a single phone number where employees can report any type of leave.

Group Health

- In a recent letter, the Everett clinic inadvertently informed Alliant Plus members they could no longer access care at the clinic. Those letters were incorrect; the clinic has sent a correction to all members.
- Group Health has revised ID cards to include additional information, including prescription drug benefits. Members began receiving the new cards as their contracts renewed, beginning July 1, 2003. The process is scheduled to be complete by May 2004.
- Group Health added a clinic in eastern Washington.

Jefferson Pilot

- Jefferson Pilot has formed a strategic alliance with MassMutual to offer individual disability insurance in conjunction with Jefferson Pilot's group long- and short-term disability products.

KPS Health Plans

- Effective March 1, 2003, KPS began contracting with Providence network providers in Oregon and Southwest Washington to provide members with access in those areas. In addition to Providence, KPS members have access to First Choice providers in Washington (outside KPS' service area), Alaska, Montana and Idaho and MultiPlan providers in all other areas nationwide.

Magellan Behavioral Health

- Most of Magellan's local EAP operations will move from Tacoma to St. Louis in November 2003. Account management will remain in the Tacoma office. Several functions, such as training, design, implementation and critical incident stress debriefing management and support are already located in St. Louis.

Premera

- Premera Blue Cross and Premera Blue Cross and Blue Shield of Alaska rolled out their "Generics – Yes!" program in April to promote the effectiveness and cost savings of generic drugs. The Generics – Yes! website includes a function to calculate the cost difference between generic and brand name drugs, a list of generic drugs coming to market and other initiatives to control prescription drug costs.

Regence

- Harrison Memorial Hospital in Bremerton terminated their contract with Regence effective April 30, 2003.
- In order to streamline operations, Regence will close some of its outlying sales offices and consolidate customer service centers in Burlington and Tacoma beginning the fourth quarter of 2003.

WSA

- The WSA awarded Acordia the role of employee benefits consultant effective July 1, 2003. The NWTech trust operation, which is currently administered by Acordia, will remain separate from WSA trust operations.

Small Business Health Insurance Reform Goes National

In the last issue of the *K&P Benefits Insider*, we reported on the state legislature's debate over "bare bones" plans for small businesses. Under proposed laws, insurers would be free to design plans without state-mandated benefits to reduce the cost of health insurance for small companies. Opponents argued that mandated benefits were important for consumer protection and should not be tampered with.

On a federal level, the House of Representatives has passed a bill (House Resolution 660) allowing small businesses to band together through national trade associations to offer group insurance. The bill allows associations to obtain coverage through an insurance carrier or self-insure, as many larger companies do.

While it is generally agreed that forming large associations will provide more flexibility and lower costs, opponents say these advantages would not apply to all small companies. Without state limitations, opponents fear associations would choose to cover only younger, healthier workers, leaving those outside the associations with even higher costs than before. An amendment that would provide subsidies through a Department of Labor program failed to generate enough support.

Bill supporters defend their position, claiming restrictions in the bill prohibit pricing based upon a worker's health status, to the extent states already prohibit such pricing. No eligible worker would be denied coverage and all businesses belonging to trade associations would have to be offered coverage.

The bill now moves on to the Senate for a vote. Some resistance is expected so it is not clear whether the bill will be passed.

Health Savings Account Legislation

On June 26, 2003, the U.S. House of Representatives passed the Health Savings and Affordability Act of 2003 (H.R. 2596). This act would create health savings accounts (HSAs) to replace Archer medical savings accounts (MSAs). Since the Senate has passed a similar version of this bill, a conference committee will now work to reconcile the differences between the two versions.

HSAs would allow tax-free contributions and reimbursements for qualified medical expenses that have not been reimbursed under another health plan. To be eligible for an HSA, an individual must be either uninsured or covered by a health plan meeting the minimum deductible requirements of $500 for self-only coverage and $1,000 for family coverage. The maximum contribution amounts would be $2,000 for self-only and $4,000 for uninsured individuals or family coverage.

In addition to creating HSAs, the legislation proposes a rollover allowance for Flexible Spending Accounts (FSAs). An FSA participant would be allowed to roll up to $500 of unused funds to the following year's FSA or to an HSA. If an individual is not eligible for an HSA, the $500 could be transferred to a qualified retirement plan.

If enacted, this legislation could have a significant impact on participation in employer-sponsored Flexible Spending Accounts. With the elimination of the "use it or lose it" stigma, employers would most likely see a substantial increase in FSA participation.

Prilosec to be Available Over the Counter

Prilosec, prescribed to adults who suffer from frequent heartburn, is expected to be available over the counter in late September of this year.

A proton pump inhibitor (PPI), Prilosec blocks the secretion of stomach acid. Doctors prescribe PPIs to treat a number of gastrointestinal conditions including: heartburn, ulcer and gastroesophageal reflux disease.

Contact the Kibble & Prentice Employee Benefits Tech Team

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