

K&P Benefits Insider

Timely information for the dynamic world of employee benefits

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

Winter 2004; Volume 7, Issue 1

CONGRESS APPROVES HEALTH SAVINGS ACCOUNTS

On November 25, 2003, Congress approved Health Savings Accounts (HSAs) as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. With President Bush's signature on December 8, the new legislation took effect January 1, 2004.

An HSA is a tax-favored account for out-of-pocket medical expenses (and certain medical premiums) as defined in Internal Revenue Code Section 213(d). Under the Act, individuals covered by a health plan with a minimum deductible of \$1,000 for self-only coverage and \$2,000 for family coverage qualify for an HSA. Individuals and employers may make pre-tax contributions to these accounts, up to the deductible amount each year. Maximum contributions are capped at \$2,600 for self-only coverage and \$5,150 for family coverage. An additional "catch-up" contribution of up to \$1,000 per year for individuals age 55 to 65 is also allowed.

In addition to creating HSAs, the Act amends Code Section 125 to allow the offering of HSAs under a cafeteria plan. Balances in an HSA

can be rolled over each year or transferred to another HSA or Archer Medical Savings Account. An individual may keep an HSA for life and transfer assets to a spouse, tax-free, upon death.

The Act repeals the 1099 reporting requirement for payments, in excess of \$600, made to medical service providers through the use of debit or credit cards that are linked to flexible spending or health reimbursement arrangements. This will apply to payments made after December 31, 2002.

An earlier version of the legislation allowed limited rollovers for health flexible spending accounts. This provision was not included in the final version of the bill.



Contact the Kibble & Prentice Employee Benefits Tech Team

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Clarification of Section 132 Regulations: Seattle Area 132 Transit Reimbursement Plans May No Longer Be Offered

Under Section 132 Transportation Plan regulations, employers may not sponsor a cash reimbursement plan for transit expenses if transit vouchers are readily available for distribution to employees. The IRS had not previously defined the term “readily available,” stating only that vouchers are not readily available if the employer is subject to significant administrative costs. The IRS did not provide guidance as to what constitutes “significant administrative costs.”

The IRS has now provided a clear definition of readily available. Effective January 1, 2004, the IRS will consider vouchers readily available unless they are subject to a financial or non-financial restriction.

Financial Restriction: The “1% Rule”

Vouchers are readily available if the average annual administrative charges the employer expects to incur for transit vouchers are less than 1% of the voucher’s average annual value. In making the 1% determination, employers may not include the following expenses:

- ◆ Delivery charges of \$15 or less
- ◆ Internal storage
- ◆ Internal distribution
- ◆ Internal accounting
- ◆ Internal reconciliation
- ◆ External fees imposed by a third-party other than the voucher provider

Non-financial Restrictions

The IRS will not consider vouchers readily available if an employer is subject to one of the following restrictions:

1. *Unreasonable Advance Purchase Requirements* – The employer cannot make purchases at regular intervals (ex. monthly) or the provider does not provide the vouchers within a reasonable amount of time after receiving payment.
2. *Unreasonable Purchase Quantity Requirements* – The voucher provider does not offer purchase quantities that are reasonable for the number of employees participating. For example, it would be unreasonable if the employer has to purchase \$1,000 worth of vouchers at a time but only needs \$250.
3. *Inappropriate Limitations on Denominations that are Available for Purchase* – The voucher denominations are unreasonable based on the amount needed by employees. For example, vouchers in increments of \$5 are considered readily available, while vouchers in increments of \$50 would not be appropriate if employees’ monthly expenses are less than \$50.

Seattle-area businesses may participate in the “Commuter Bonus Program.” Vouchers, purchased from King County Metro, may be used for the following transportation providers:

- ◆ Metro
- ◆ Community Transit
- ◆ Intercity Transit
- ◆ Everett Transit
- ◆ Island Transit
- ◆ Kitsap Transit
- ◆ Pierce Transit
- ◆ Washington State Ferry System

There are currently no additional administrative fees or delivery charges. Vouchers can be purchased as often as needed and are printed within 5 days of receiving payment. The minimum purchase amount is \$100 and vouchers are offered in \$5 denominations.

Under the current circumstances, these vouchers are considered readily available. Therefore, employers with access to this program may not offer a cash reimbursement plan for transit expenses.

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UPDATE: Reimbursement of Over-The-Counter Products

There is an important change that participants in health flexible spending accounts need to take into consideration when making their elections for the upcoming plan year. In September 2003, the IRS announced that over-the-counter (OTC) products are eligible for reimbursement through Health FSA's (Flexible Spending Arrangements) if the governing Plan Document allows.

Now that many popular prescription drugs are available OTC, it is important to communicate the benefits of this change as well as some of the administrative guidelines for obtaining reimbursement.

There are three basic categories of OTC medicines and products:

1. *No Prescription Required.* These products are all eligible for reimbursement through a Health FSA. Examples include allergy medications; antacids; bandages; cold/flu medications; cough medicines; eye drops; nicotine gum/patches; pain reliever medications; thermometers.

2. *Prescription Required.* These products are eligible for reimbursement if they are recommended by a doctor to treat a medical condition. A copy of the doctor's note or prescription must be submitted with the claim. Examples include acne treatment medications; anti-depression medications; fiber supplements; naturopathic/homeopathic products; prenatal vitamins; sunscreen; weight loss medications.

3. *Not Qualified.* These products are not eligible for reimbursement through a Health FSA. Examples include cosmetics (lip balm, face creams/washes); toiletry/sundry items (toilet paper, toothpaste, feminine products); vitamins for general well being.

Documentation for over-the-counter medicines and products must include the product name, purchase price, and purchase date. The IRS guidance indicates that participants are not allowed to "stockpile" OTC products, so quantity limitations should apply.

Plan sponsors and administrators are expecting to see an increase in participation and contribution amounts for the upcoming plan year due to this IRS ruling.

Massachusetts Supreme Court Rejects Ban on Same-Sex Marriage

The Massachusetts Supreme Judicial Court has ruled that Massachusetts' law denying same-sex couples the right to marry is unconstitutional. The justices gave the state Legislature 180 days to change state law to comply with the ruling.

In its decision, the court wrote that Massachusetts could not deny "the protections, benefits, and obligations conferred by civil marriage to two individuals of the same sex who wish to marry. The Massachusetts Constitution affirms the dignity and equality of all individuals. It forbids the creation of second-class citizens. We declare that barring an individual from the protections, benefits, and obligations of civil marriage solely because that person would marry a person of the same sex violates the Massachusetts Constitution." In support of their ruling, the Court referenced legal challenges to Canada's same-sex marriage ban as well as other Massachusetts cases.

For employers, the November 18th decision raises many questions, although it will be some time before the full effect of the ruling is known. Further complicating matters are the federal "Defense of Marriage Acts," similar same-sex marriage bans in 37 states (including Washington) and federal ERISA law exempting employers from providing benefits to same-sex spouses.

The ruling details benefits that must be extended to same-sex spouses, including public and private pensions, employer health care benefits, Medicaid and life insurance.

Health Care Benefits: While many companies already cover domestic partners, the ruling will necessitate a change to accounting procedures because the benefits provided to domestic partners may no longer be taxable under Massachusetts state law. Federal taxes will still apply, however, meaning companies may have to keep two sets of tax records.

Pension and Retirement Benefits: The ruling stipulates that the state and municipalities must extend pension benefits to the same-sex spouse of an employee who dies. Pension benefits that are governed by federal law, such as 401(k) plans, will not be subject to the ruling and employers will be under no obligation to offer these plans' benefits to same-sex spouses.

It remains unclear what rights and benefits a same-sex married couple from Massachusetts would have in other states since a majority of other states have passed "defense of marriage acts" that refuse to recognize gay marriages. The possibility exists that a same-sex couple moving from Massachusetts to another state could challenge the law of that state.

CARRIER UPDATES

Aetna

Aetna's contract with Valley Internal Medicine (VIM) terminated as of January 1, 2004.

The Pacific Cataract & Laser Institute (39 specialists) and Family Care Network (41 PCPs and 9 Specialists) joined the Aetna network on August 1, 2003.

BENU

BENU has expanded coverage to Oregon and Southwest Washington through CIGNA and Kaiser Permanente. Mid-size employers with at least 75 employees can begin accessing the multiple plan choices offered by the two health plans for January 1, 2004 effective dates.

CIGNA

Effective January 1, 2004, CIGNA began covering brand-name prescription diabetic test strips at the brand-name copayment or coinsurance level (second tier). Previously, brand-name test strips were covered at the generic copayment or coinsurance level (first tier). CIGNA Pharmacy Management sent letters to active members who have utilized brand-name diabetic test strips in the last three months. Certain New Jersey, New York and Texas members will be permitted to continue their coverage based on state laws.

CIGNA health plan participants with mental health coverage through CIGNA Behavioral Health are no longer required to get prior approval to see network providers for routine care. This change took affect July 1, 2003.

Numerous enhancements became available to the CIGNA consumer portal, myCIGNA.com, effective September 2003. Site improvements include enhanced navigation, the ability to print a temporary CIGNA ID card, expanded claims reporting capabilities, more benefit details, consolidated contract information for CIGNA HealthCare, Dental Expense Tracker, and Tel-Drug Mail Order History.

CIGNA International has begun marketing an international EAP to clients with medical coverage effective January 2004. CIGNA international clients, with 2 to 9 employees, will automatically be covered for International Telephonic Assist, the first level of service. The EAP will offer access to behavioral counseling with a health professional 24 hours a day, 7 days a week.

Fortis Benefits

Fortis is now offering Medical Premium Payment Supplement (MPPS) as an option with their LTD coverage. This option will pay employers a pre-determined amount towards monthly medical premium amounts for a disabled employee. Premiums are paid for 36 months or until a change in the Definition of Disability from Own Occupation to Any Occupation.

The "HealthSolutions" non-insurance discount program is now available. The program offers discounts on vision, nurse hotline, counseling, pharmacy, chiropractic, travel assistance and legal services. Participants in Voluntary Life or Voluntary Disability plans will receive one selection automatically with the opportunity to purchase additional discounted services.

Group Health Cooperative

Group Health and Overlake Medical Center have entered a strategic partnership to build a new specialty medical care tower, set for completion in 2007, on the grounds of the Overlake campus.

Options Health Plan members who get a prescription from an out-of-network provider can now fill it at a Group Health pharmacy. Members may experience lower coinsurance payments because of Group Health's ability to purchase some drugs at a lower cost than retail pharmacies.

Group Health has launched another phase of their suite of enhanced on-line services. Members who get care at a Group Health medical center can now see lab results and portions of their medical record, view provider visit summaries, e-mail a specialist who's caring for them, and review diagnoses of their current health conditions at the MyGroupHealth website.

Loudes Medical Center will be joining the Group Health network to provide services to Tri-City members effective January 1, 2004.

Magellan

On October 8, 2003, the Bankruptcy Court recognized Magellan's Plan of Reorganization. The company expects to exit Chapter 11 with a significantly strengthened structure after having reduced debt by approximately \$600 million and attracting \$150 million in new equity.

Premera Blue Cross

Premera will begin a new COBRA rate structure beginning January 1, 2004. Currently, spouses and children covered

under COBRA are billed the same rates as active participants. Under the new policy, a spouse or child electing coverage without the employee will be billed the employee rate. Each child or children only (without parent or guardian) will be billed the employee rate. Spouse with a child or children, will be billed the employee rate and the child or children rate.

The Washington Insurance Commissioner and Premera have agreed that the commissioner will decide on Premera's proposal to become a public company by March 15, 2004.

Effective July 1, 2004, Premera changed the drug class known as "leukotriene antagonists," including Singulair, Accolate and Zyflo, from Tier 2 to Tier 3 status. These medications are used for asthma and allergy treatment.

A generic equivalent for Prilosec is now available. Prilosec is a heartburn medication. Premera will change Prilosec to a Tier 3 (non-preferred drugs) drug effective January 1, 2004. Members who chose Prilosec over the generic equivalent between August 20, 2003 and December 31, 2003 are required to pay the Tier 2 copay and the cost difference between the brand-name and generic versions.

Premera moved the following drugs to Tier 3 effective July 1, 2003: Beconase, Beconase AQ, Nasacort, Nasacort AQ, Seconal, Serzone, Vancenase, Vancenase AQ. The following drugs were removed from Premera's Preferred Drug List (PDL) effective July 1, 2003 because generic equivalents are now available: Accutane, Atrovent Nasal Spray, Didronel, Nolvadex, PEDIAPRED, Tambocor, Zarontin 250mg caps.

Proliance Surgeons was terminated from the Dimensions Foundation network effective September 1, 2003. They remained on the Heritage network. Proliance's 133 physicians and 35 offices provide orthopedic and general surgery services throughout King, Snohomish, Pierce and Skagit counties.

Effective January 1, 2004, Premera's Life and Disability company, States West Life, has changed their name to LifeWise Assurance Company.

Prudential Financial

Prudential has partnered with ComPsych to begin offering an Employee Assistance Program (EAP).

On-line billing is now available from Prudential. Clients can use wire transfer or Electronic Funds Transfer (for Online Roster Billing only) payments and the archive feature can maintain copies of past bills for up to three years.

Regence Blue Shield

Professional services for MultiCare Health System and Franciscan Medical group will not be covered for Regence

Healthy Options (Medicare Supplement policies) and Basic Health (state-sponsored plan for low-income individuals) plans effective January 1, 2004. Regence and these provider groups were not able to agree on reimbursement amounts. Hospital services for these providers will not be affected by this change. A total of 2,500 Basic Health and Health Options members are affected by this change. Regence sent affected members a letter notifying them of the change in mid-October.

CareEnhance and Special Beginnings programs will be added to Community and Merit medical plans (1-199 employees) as groups renew on or after January 1, 2004. CareEnhance offers 24-hour nurse advice service with health resources by phone. Special Beginnings is a maternity support program that helps women have healthier babies.

Regence began offering the new Regence Advantages program that offers discounts on hearing exams, vision exams, hearing aids and vision hardware. These programs are included at no additional cost.

Since recent preliminary studies have shown digital mammograms may be as reliable as flat screen mammograms, Regence began covering digital mammography at the same provider reimbursement amounts as flat screen mammography for both screening and diagnosis.

Columbia Dental of Washington has changed the name of their company to Willamette Dental. Columbia Dental clinics will begin changing their signs to reflect this change.

Medco

Medco announced a proposed settlement of a class action lawsuit involving complaints filed by plan participants. The lawsuit's key allegation is that Medco made formulary and pharmacy program decisions to benefit its parent company, Merck. The class includes any plans that Medco Health has administered a pharmacy benefit at any time since December 17, 1994. Members have the option of (1) joining the settlement, (2) doing nothing and be bound by the release but not share in the proceeds, (3) opting out of the settlement, or (4) objecting to the settlement. Medco notified members of the settlement between July and November 2003. The deadline for settling a claim is February 9, 2004. For more information, visit www.erisasettlement.com.

United Healthcare

United Healthcare will be replacing Medical ID cards as groups renew beginning January 2004. The new cards will store information about eligibility and copayments, include the names of dependents, and change the ID number from the member's Social Security number to an alternative number.