

MILLER JOHNSON
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HEALTH CARE REFORM
PRIORITY ALERT

Employee Benefits ▪ September 29, 2010

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Introduction

Mary V. Bauman, Chair

September 23, 2010 was a date widely reported in the news media as the "effective date" of Health Care Reform (the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act). Those reports were misleading. The insurance market reforms of Health Care Reform must be implemented with respect to an employer's health plan no later than the first day of the first plan year beginning on or after September 23, 2010. Because the plan year for most employer plans is the calendar year, this means the effective date is January 1, 2011 (and not September 23, 2010).

Since April, Miller Johnson's Health Care Reform Team has already issued seven *Client Alerts* and articles to keep you informed not only of the legislation but of the many subsequent sets of regulations issued by the federal government.

Now, this issue of our new *PRIORITY ALERT - Health Care Reform* newsletter updates you on the following recent guidance.

IN THIS ISSUE

Impact of Health Care Reform on OTC Drugs

Health Care Reform revised the definition of "medical expenses" as it relates to over-the-counter (OTC) drugs. Effective January 1, 2011, an OTC drug is reimbursable as a medical expense only if the drug is obtained with a prescription (even though a prescription is not required to obtain the drug).

Prior law allowed the cost of OTC drugs to be reimbursed as medical expenses by medical flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), health savings accounts (HSAs) and Archer medical savings accounts (Archer MSAs). Health Care Reform permits the cost of a drug or medicine to be reimbursed as a medical expense only if it is a prescribed drug or insulin.

The IRS recently published Notice 2010-59 which discusses the impact of Health Care Reform on OTC drugs. Here are some of the implications of this new rule:

- The cost of an OTC drug may be reimbursed from an FSA, HRA, HSA or Archer MSA only if the participant obtains a prescription for the OTC drug. For this purpose, a prescription is any written or electronic order that meets the legal requirements for a prescription in the state in which the OTC drug is purchased.
- OTC expenses other than drugs may continue to be reimbursed without a prescription. This may include items such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits. The pre-Health Care Reform rules apply to these OTC expenses.
- The new rule applies to expenses incurred after December 31, 2010, regardless of the plan year of the plan under which the participant would otherwise obtain reimbursement. It also applies regardless of any 2½-month grace period for an FSA.

Plan sponsors should inform participants of this new rule as soon as possible for two reasons.

First, many participants are currently or soon will be going through open enrollment for FSAs. If a participant is more limited in the opportunity to be reimbursed for OTC drugs, it may affect how much the participant chooses to contribute to the participant's FSA for the next plan year.

Second, participants may be able to control the timing of their purchases of OTC drugs. A participant will want to make those purchases no later than December 31, 2010 if the participant wants to be reimbursed for the cost as a medical expense.

Some plan sponsors use debit cards to administer FSA and HRA programs. According to the IRS, current debit card systems are not capable of substantiating whether an OTC drug has been prescribed. Therefore, as a general rule, FSA and HRA debit cards may not be used to purchase OTC drugs after December 31, 2010. However, the IRS said it would not challenge the use of an FSA and HRA debit card for expenses incurred through January 15, 2011 if the pre-Health Care Reform requirements for these debit cards are otherwise satisfied. Debit cards may continue to be used in FSA and HRA programs for eligible medical expenses other than OTC drugs.

Cafeteria plans must be amended to comply with the new rules regarding the reimbursement of OTC drugs. The amendment must be adopted no later than June 30, 2011, retroactive to January 1, 2011 (or January 16, 2011 for FSA and HRA debit card purchases).

Please contact a member of our Health Care Reform Team if you have any questions regarding these new rules.

New Health Care Reform FAQs Address Definition of Dependent Child and Other Issues

The Departments of Labor, Treasury and HHS have jointly issued a series of frequently asked questions (FAQs) regarding Health Care Reform. Here are some highlights:

HEALTH PLANS WILL NOW BE ABLE TO IMPOSE ADDITIONAL ELIGIBILITY CONDITIONS ON CERTAIN CATEGORIES OF DEPENDENT CHILDREN.

Under the May 2010 regulations concerning the new definition of older dependent child, a health plan is prohibited from imposing any condition on a child's coverage such as full-time student status, residency, or financial/tax dependency. While most employers did not object to these new requirements for the "primary" categories of children such as natural children, adopted children and stepchildren, employers were concerned about not being able to impose these requirements for other categories of children such as grandchildren and children covered by legal guardianships—circumstances where the employee is not the child's parent. For these latter categories, employers want to impose additional requirements for two reasons. First, employers want to make sure the employee has a minimum level of responsibility with respect to the child. Second, health coverage for children in these latter categories cannot be provided on a tax-free basis unless the child is otherwise the employee's tax dependent. (Under guidance issued by the IRS in April 2010, only older children who are the employee's natural child, adopted child, child placed with the employee for adoption, stepchild or foster child can be covered under an employer's health plan on a tax-free basis through the end of the year in which they turn 26 if not otherwise the employee's tax dependent.)

Under the FAQs, if a plan chooses to cover dependent children in categories other than natural child, adopted child, child placed with the employee for adoption, stepchild or foster child, it will now be permitted to impose additional conditions on the child's eligibility for health coverage, such as the condition that the child be dependent on the employee for income tax purposes. For example, an employer could allow an employee's grandchild or a child covered by a legal guardianship with the employee to be eligible to participate in the plan until age 26, provided the child is the employee's tax dependent. This guidance should provide welcome relief to employers wrestling with how to define dependent child under their plan on a going forward basis.

WILL THE GRANDFATHERED RULES BE MODIFIED?

In June 2010, regulations were issued setting forth the circumstances under which grandfathered status may be lost. The regulations have been criticized as being overly restrictive. For example, the regulations indicate that any change in insurance policies will trigger a loss of grandfathered status. The new FAQs indicate that the federal government will soon issue additional guidance addressing the circumstances under which health plans may change carriers without relinquishing their grandfathered status. In addition, the grandfathered plan regulations will be revised and issued in final form next year.

Please contact a member of our Health Care Reform Team if you have any questions regarding these new rules.

Enforcement Grace Period Issued For New Internal Claim and Appeal Procedures

Non-grandfathered plans under Health Care Reform must comply with additional internal claim and appeal procedures to provide participants with additional rights. Further, non-grandfathered plans must offer a new external review process. These requirements for non-grandfathered plans apply as of the first day of the first plan year beginning on or after September 23, 2010. Many employers, third party administrators and insurers indicated that it would be difficult to make the procedural and computer system changes necessary to implement the new internal claim and appeal procedures by the effective date. On September 20, 2010, the Department of Labor issued Technical Release 2010-02 announcing that the federal government will not take any enforcement action against a health plan with respect to most of the new internal claim and appeal requirements until July 1, 2011, as long as the plan is working in good faith toward implementation of the new requirements.

The Department of Labor issued an earlier Technical Release in August setting forth an enforcement safe harbor for compliance with the new external review requirements for non-grandfathered plans. Look for another Health Care Reform Client Alert from Miller Johnson in the near future providing more details on the safe harbor as well as a comprehensive overview of the new internal claim and appeal requirements and external review procedures.

Please contact a member of our Health Care Reform Team if you have any questions regarding these new rules.

Are Dental and Vision Plans Subject to Health Care Reform?

"Excepted benefits" under the HIPAA portability rules, such as dental-only plans, vision-only plans and most medical flexible spending accounts are not subject to Health Care Reform.

For this purpose, a dental only plan or vision only plan is a separate plan from the employer's medical plan. In addition, a dental and/or vision benefit under a medical plan can also qualify as a dental-only or vision-only plan where participants may separately elect the dental and/or vision benefit (apart from the medical benefit) and where there is a separate premium obligation for the dental and/or vision benefit (again, apart from the medical benefit).

If a dental or vision benefit qualifies as an excepted benefit, the insurance market reforms and other requirements of Health Care Reform do not apply. However, employers can voluntarily choose to comply with one or more provisions of Health Care Reform. For example, the employer may want to voluntarily adopt the new definition of older dependent child for purposes of the dental and/or vision benefit so the eligibility rules are consistent with the medical plan.

Please contact a member of our Health Care Reform Team if you have any questions regarding these new rules.

Miller Johnson's Health Care Reform Team Aims to be Your Valued Resource

Our Health Care Reform Team—15 attorneys from six practice groups—provides guidance on this complex and ambiguous legislation. We're monitoring important changes to health insurance coverage, employer-sponsored health plans, tax provisions, fraud and abuse, long-term care and more.

We pledge to guide and counsel clients on the tremendous impact this legislation will have on their businesses financially and strategically over the coming years.

The firm's web site will host the Health Care Reform Team documentation and activity. Visitors to the Health Care Reform Team page of the Practice Areas section at www.millerjohnson.com will find a valuable source of information and resources. In addition to the practice description and attorney information, you will be able to find:

- **Publications** – all the *Client Alerts* sent out since April 2010
- **Resources** – links to legislative acts and regulations on government web sites
- **Events** – webinar and seminar materials
- **Experience** – articles in business publications our attorneys were interviewed for and professional groups and conferences they did presentations at

If you would like to receive our newsletter and alerts, please send an e-mail to healthcarereformteam@millerjohnson.com with the subject line "Add to mail list."

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