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FOCUS

On Benefits

In This Issue

Which OTC Drugs are Reimbursable?

No sooner did an IRS Revenue Ruling authorize FSA/HRA reimbursement of over-the-counter medicines than a question arose, "which OTC medicines?" For example, Visine: is it to control eye irritation, or is it to enhance appearance by reducing redness? For now, employers should begin answering this question and others by:

- Reviewing the plan document to ensure authority for OTC reimbursement.
- Making sure the OTC drug is generally accepted as a medicine or drug.
- Assuring that the item is not a toiletry or cosmetic.
- Requiring that the OTC drug be legally acquired.

Also helpful is *The Physicians' Desk Reference for Nonprescription Drugs and Dietary Supplements*. This book can be purchased by visiting www.pdr.net. There is also a list of OTC at www.pdrhealth.com/drug_info/otcdrugprofiles/alphaindexa.shtml. Meanwhile, employers should consider developing a plan of action for reimbursing OTC drugs under their health FSA. Some steps to follow are:

Some employers have chosen to develop two drug lists: Those OTC medicines that are clearly approved for reimbursement, compared to items that have a dual purpose and require extra scrutiny (such as sunscreen). You should also begin to list which items are definitely excluded.

Beware that quantity issues can pose problems. Does the plan sponsor or TPA have a system in place that will allow it to catch someone buying 500 bottles of aspirin? The IRS has indicated that it

will approve expenses that allow for someone to reasonably stock a medicine cabinet — but there's no way to justify buying aspirin by the case.

Finally the IRS has said that documentation of expenses is still key. If an inappropriate expense is reimbursed there needs to be a system in place that will audit payments and correct any errors.

California "Pay or Play" Statute

Before his defeat, California Governor Gray Davis signed the controversial Senate Bill 2 requiring California employers to provide health insurance to their employees. Questions abound and will not likely dwindle for some time. We will track the answers and report on them in future issues of *FOCUS on Benefits*. Here are some answers to immediate concerns:

Who is affected?

Assuming a related tax credit provision is enacted by the legislature, all employers with 20 or more employees in the state of California have the potential to be covered by the new mandate. If that follow-up tax credit is *not* enacted, the law will only apply to employers with 50 or more employees in California. *Any* company with the requisite number of employees in California will be affected by the law.

> **Large employers** — Defined in the statute as those with 200 or more employees, will be affected beginning January 1, 2006.
>
> **Medium employers** — Defined in the statute as those with at least 50 but not more than 199 employees, will first be affected beginning January 1, 2007. Employers with at least 20 but no more than 49 employees are exempt — unless the follow-up tax credit is enacted.
>
> **Small employers** — Employers with at least two and no more than 19 employees would be exempt from the new law.

Is there a way to avoid the mandate?

Any employer who is part of an expanded definition of a controlled group under the Internal Revenue Code definition will be counted as a single employer for this purpose. Generally, that rule requires an 80 percent ownership share for the two entities to be considered to be in the same controlled group. New entities will be counted as a single employer if the employer owns at least 50 percent of the entity.

For example, if Ohio Corporation — a large employer by this definition — has 25 salesmen in California, then it will only be subject to the rule if the future tax credit is enacted. If they employ 50 or more employees in California, Ohio Corporation will be subject to the statute on January 1, 2007. If Ohio Corp. were to set up five different subsidiaries in California, each owned over 50 percent and each with 10 employees, it would still be subject to the 2007 effective date. The subsidiaries with California employees will be counted as single employer for purposes of the statute. So, Ohio Corporation will have

to either pay the tax or provide the minimum levels of health coverage for its California workers beginning January 1, 2007.

Who must be covered?

All employers must cover their own employees (defined as "enrollees" in the statute) or pay the applicable fee/tax.

Large employers (those who employ 200 or more employees in California) must cover the employees *and their dependents* or pay the applicable fee/tax for the employees and their dependents.

Who qualifies as an enrollee?

An enrollee is a worker who works at least 100 hours per month for a minimum of three months for any one employer. In a somewhat surprising decision, legislators chose to adopt an extremely broad definition which includes sole proprietors and partners who work at least 100 hours per month in the business. Although they may have chosen to be uninsured, they will now be subject to the mandate as well.

If an enrollee works for more than one employer, which provides coverage?

Legislation is somewhat ambiguous on this point. It is hoped that California will issue guidance well ahead of the law's effective date.

Who are considered as dependents?

Dependents are defined in the statute as the spouse, domestic partner, minor child, or a child over 18 who is dependent on the employee (as specified by the Managed Risk Medical Board). Dependents who are covered by another employer or who are eligible for enrollment because of their own employment status are not dependents for this purpose. This provision of the law is intended to prevent the employer from having to provide double coverage for those dependents.

What is the required fee/tax?

All employers covered by the statute and who purchase coverage through a state health program will be required to contribute a pro rata share for the cost of providing the medical coverage under the program.

Employers may pass up to 20 percent of the cost to the enrollees but employers are still required to collect the enrollee portion and remit that to the Board. Employees whose wages are 200 percent or less of the federal poverty guidelines (for an individual if the coverage is for the enrollee alone or for a family of three if the coverage is for the enrollee and dependents*) cannot be required to contribute more than five percent of their wages for the coverage*.

What if an employer is already complying?

Nothing in the law prohibits an employer from voluntarily providing health benefits. In addition, an employer who provides proof of health care coverage will be entitled to a credit against the fee/tax.

What type of coverage qualifies for the credit?

Acceptable coverage would be: a health service plan under the California law that applies to HMOs, any other plan the includes coverage for physician services, inpatient and outpatient hospital services, diagnostic and therapeutic lab and radiologic services, home health care, preventive health care, and emergency health care (and otherwise meet the standards required for PPOs under California law). Several types of plans are specifically excluded: Medicare supplement, vision-only, dental-only, Champus-supplement (military coverage) insurance, hospital indemnity, accident-only, and specified disease insurance that pays benefits on a fixed benefit, cash-payment-only basis are not the types of coverage that would be eligible for a credit against the fee.

Plans under a Taft-Hartley fund — or other collectively bargained plan — and other employer plans that provide sufficient benefits (including multiple employer welfare arrangements) are also acceptable if they meet those same standards. Certain other coverage that does not apply to private employers also qualifies.

Failure to comply

If an employer fails to make the make the proper contribution to the fund, that employer will be assessed a penalty of 200 percent of the amount they would have otherwise paid.

What about ERISA?

Part of the controversy concerning this measure revolves around ERISA. Employee benefit laws are governed by federal law as set forth under ERISA. States are prohibited from establishing any laws that would require that employers take some benefit actions (though an exception applies to ERISA which allows states to control insurance carriers, thereby indirectly affecting employers that purchase insured policies).

We anticipate litigation as employers seek to challenge the law. It is possible that the courts would strike down the law, it is also plausible that the law will survive under the theory that the law does not *mandate* that employers offer benefits. Proponents of the law would likely argue that the law merely establishes an employer tax to apply in situations where the employer fails to "volunteer" to provide health benefits which are at least 80 percent subsidized. You may remember that the federal courts allowed a New York law to stand which indirectly subjected all employer group health plans to a hospital surcharge — even though the surcharge amounted to a state tax directly absorbed by employer sponsored benefit plans.

Could the law be rescinded?

It is unclear what steps Governor-elect Schwarzenegger might take to address the business community's concern. Rescinding the law would require new legislation and, unfortunately, proponents of the law control two/thirds of both houses of the California legislature.

What should employers do now?

The law does not take affect until January 1, 2006 at the earliest so employers have time to consider their options. In addition, there are several ambiguous provisions so employers may want to wait to see how some of these issues are resolved before making any final decisions.

HIPAA's Pre-Existing Condition Rules: Stable

Regulations dealing with HIPAA's pre-existing condition exclusions and other issues were completed in 1997 but are working their way through the channels of clearance. Russ Weinheimer, a senior attorney in the IRS Health and Welfare Branch of the Office of Chief Counsel, told an American Bar Association conference that forthcoming regulations will not include major changes from the 1997 rules but will include, "small, fine-tuning changes." Weinheimer noted that an additional topic that likely will be proposed in conjunction with the forthcoming regulations is the interaction of the HIPAA regulations with FMLA.

Other projects

The agencies also are working on guidance projects related to the Newborns and Mothers' Health Protection Act and Woman's Health and Cancer Rights Act, though progress on those projects may be slow. With regard to Newborns and Mothers' Health Protection Act, at least, Weinheimer said major changes in the current rules are unlikely.

Unemployment Insurance Expansion Rescinded

The Clinton administration generated a rule that would permit state unemployment insurance systems to pay benefits to people who were out of work because of the birth or adoption of a child. The Bush administration DOL has announced a finalized proposal to rescind that rule.

The DOL noted that no state actually adopted the Clinton administration rule. Recent years have seen a depletion of surpluses in state unemployment compensation funds, so implementation is even less likely. This action by the DOL will help to preserve those funds for the purpose of insuring unemployed individuals who are able and available to work.

Proposal to Mandate Infertility Treatment

Congressman Anthony Weiner (D-NY) has introduced the Family Building Act of 2003 (H.R. 3014), which would amend ERISA, the Internal Revenue Code, and the Public Health Service Act to require group health plans and health insurance issuers to provide coverage for the treatment of infertility.

In a statement of findings, H.R. 3014 notes that infertility affects more than six million Americans, which represents about 10 percent of the reproductive age population; and that recent improvements in therapy make pregnancy possible for more couples than in past years. The bill further observes that the majority of group health plans do not provide coverage for infertility therapy.

As specified by the proposal, in the case of a group health plan and a health insurance issuer offering group health insurance coverage that provides coverage for obstetrical services, the plan or issuer would have to include coverage for the treatment of infertility. Accordingly, the plan would have to cover treatment that is "deemed appropriate" by the participant and the treating physician. Covered services would include ovulation induction, artificial insemination, in-vitro fertilization, and other treatments. Those deemed "experimental" by the Secretary of Health and Human Services would not be covered.

Under the bill, a plan could not impose deductibles, coinsurance, and other cost-sharing or other limitations for infertility therapy that are greater than those imposed on other services. The bill would prohibit plans and issuers from denying participant eligibility, or continued eligibility, to enroll or to renew coverage under the plan solely for the purpose of avoiding the requirements of the legislation. A plan or issuer could negotiate the level and type of reimbursement with a provider for care provided in accordance with the bill. State laws that provide greater benefits with respect to infertility treatments would remain intact.

If adopted, the provisions of H.R. 3014 would apply to contracts entered into, or renewed, for years beginning at least six months after the date of enactment.

Since You Asked — Paying for FMLA Leave

Although the facts may differ dramatically in each situation, we often receive questions about the payment of premiums and recovering the cost of group health insurance while an employee was on unpaid FMLA leave. The following fictional example incorporates several issues that arise repeatedly and may be of use to others.

Background

Howard, an employee, takes unpaid FMLA for a total of 12 weeks over the course of a year. Howard's wife and child are suffering from the same degenerative hereditary condition that hospitalizes both. Howard did not have any paid leave that could be applied against FMLA leave, so all 12 weeks of FMLA were unpaid. Howard agreed to pay the group health plan premiums on a "pay-as-you-go" basis with after tax dollars, but Howard was unable to make timely payment. Howard's employer paid both the employer's share and the employee's share of the premiums during the FMLA leave. At the end of the 12 weeks of FMLA leave, Howard was unable to return to work because of his wife's continued illness.

Late payments/no payments

The employer should establish a written policy regarding late or non-payment of premiums. However, if there is no written policy, then the employer is not required to continue group health plan coverage for more than 30 days beyond the last payment (a separate rule applies that requires the employer to notify an employee at least 15 days before terminating coverage). If the employer has established a policy that allows the employer to terminate coverage retroactively to the date the unpaid premium payment was due, the employer may drop the employee from coverage retroactively if the employer provides a 15-day

notice to the employee. (Note: Full benefit restoration rules apply when a person returns from FMLA — even if coverage was properly terminated for non-payment during FMLA leave.)

Can the employer recover costs?

Due to the facts and circumstances connected to this situation, the employer may *not* recover its costs from the employee.

Keep in mind that FMLA imposes a fundamental requirement — the employer must reinstate the employee, upon the employee's return to work, to the same coverage that was in effect before the employee left on FMLA leave. If there is any risk that an employer might not be able to reinstate coverage should a lapse occur, the employer will have no choice but to pay for group health plan coverage.

Typically, if the employee does not return to work after the expiration of FMLA leave, then the employee must repay the employer's share of the group health plan premiums during the period of unpaid FMLA leave. However, this obligation does not exist when the employee fails to return to work because of certain "hardship events" outlined in the FMLA regulations. In this example — the continuation, recurrence, or onset of a serious health condition of the employee or the employee's family member which would otherwise entitle the employee to FMLA came into play. As a result, Howard would not be required to reimburse his employer for the portion of the employer's premiums that were paid on his behalf.

Additional leniency is granted under the regulations for certain events that are beyond the control of the employee (seriously ill newborn, job relocation of spouse, layoff of employee, "key employee" denied restoration of job). An employee is not deemed to have "returned" from FMLA leave if the return to work is for a period less than 30 calendar days.

For answers to questions about your specific FMLA situations, contact your Willis representative.

Medicare Bill Squeezes Retiree Health Plans

According to studies cited by the *Wall Street Journal*, the versions of a bill to add prescription drug coverage to Medicare passed by the U.S. House and Senate last summer would accelerate the trend of employers dropping existing health coverage for their retirees. Emory University economist Ken Thorpe estimates that a third of Medicare beneficiaries who currently have health coverage provided by a former employer would lose it if either of the Medicare bills under consideration were to become law. The Government Accounting Office (GAO) has data showing that about 30 percent of Medicare enrollees have private supplemental coverage.

The decision to try and focus limited resources on those who do not currently offer any coverage for their outpatient prescription drugs will "result in lower federal subsidies to employers," said Thorpe. This encourages employers to drop drug coverage because drug spending represents more than half of most retirement health packages.

The potential loss of private retiree coverage — which tends to be more generous than the new Medicare benefit contemplated in either the House- or Senate-passed bill — has emerged as a key stumbling block in the ongoing negotiations over the measure.

The Congressional Budget Office, using a different estimating model, has also concluded that retiree coverage would decline by about a third under the House or Senate bill. Several members of the Congressional negotiating team have said they are hearing loud complaints from seniors back home who are fearful of either bill becoming law.

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