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Mini-Med Waiver Rules and Limitations on Purchase of OTC Drugs Through FSAs, HRAs and MSAs

Mini-Med Waiver Rules

Health insurers sell, and employers buy, limited benefit plans, popularly known as “mini-med” plans which offer lower cost premiums for very limited coverage. This kind of plan/policy is popular in industries that employ many part-time, seasonal or volunteer workers, and at colleges and universities for student coverage.

Under the Affordable Care Act (ACA), group health plans and health insurers will be prohibited from imposing lifetime or annual limits on the dollar value of benefits. An exception to this rule was published in the Interim Final Regulations issued June 22. The exception sets forth allowable annual limits to be phased in over the next three years, with the complete prohibition to be effective after January 1, 2014 ([click here to view the previous Alert that addressed these phased-in annual limits](#)). The annual limits under these mini-med policies, however, generally fall far below the levels permitted by the pre-2014 exception set forth in the Interim Final Regulations. The preamble to the Interim Final Regulations, however, noted that a waiver program would be established to allow insurers to continue to offer, and employers to purchase, mini-med policies.

On September 3, the Office of Consumer Information and Insurance Oversight in the Department of Health and Human Services (DHHS) issued guidance implementing this waiver program. Under the guidance, group health plans and health insurers may apply for waivers for plans or policies offered prior to September 23, 2010, for plan or policy years beginning on or after that date. The application must be submitted not less than 30 days before the beginning of such plan or policy year, but for plan or policy years that begin before November 2, 2010, not less than 10 days before the beginning of such plan or policy year. The waiver application must include:

- The terms of the plan or policy form(s) for which the waiver is sought,
- The number of individuals covered,
- The annual limit(s) and rates applicable to the plan or policy,

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- A brief description of why compliance would result in a significant decrease in access to benefits or a significant increase in premiums for those currently covered, and any supporting documentation,
- An attestation by the Plan Administrator or CEO of the issuer certifying that (i) the plan or policy was in force prior to September 23, 2010, and (ii) that the application of the ACA's restricted annual limits would result in either a significant decrease in access to benefits or a significant increase in premiums, or both.

Waiver applications should be emailed to healthinsurance@hhs.gov, or be mailed as a hard copy to:

DHHS Office of Consumer Information and Insurance Oversight
Office of Oversight
Attention: James Mayhew
Room 737-F-04
200 Independence Ave., SW
Washington, D.C. 20201

DHHS will process the applications within 30 days of receipt, but for arrangements with plan or policy years beginning before November 2, 2010, the application will be processed no later than five days in advance of the beginning of that plan or policy year. The waiver, if granted, will be good for one year. Future waivers must be applied for annually until 2014, when the waivers will no longer be available.

For insured mini-med plans, the guidance does not clarify, if the insurer obtains a waiver for the policy purchased by an employer/plan sponsor, whether that employer/plan sponsor must also apply for a waiver for its plan? Presumably, the insurer's waiver would suffice, but that issue was not expressly addressed in the guidance.

Limitations on Purchase of OTC Drugs Through FSAs, HRAs and MSAs

The ACA limited the ability of health care flexible spending accounts (FSAs), health reimbursement accounts (HRAs) and Archer medical savings accounts (MSAs) to reimburse medical expenses for over-the-counter (OTC) drugs and medicines. Under the ACA, reimbursement can only be made if: (i) the medicine or drug requires a prescription, (ii) is an OTC drug or medicine but the individual has a prescription for it, or (iii) is insulin.

For this purpose, a prescription is a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the drug is purchased, and is issued by a person who is legally authorized to issue a prescription in that state.

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These limitations apply to OTC drugs that are purchased on or after January 1, 2011, even if the funds used were set aside in these accounts in 2010 or earlier. The compliance date applies regardless of the start date of the plan or policy year. The IRS notes, however, that items that are not medicines or drugs, but otherwise meet the definition of medical care under IRC § 213(d) (e.g., crutches, bandages, diagnostic devices such as blood sugar kits, etc.), may still be purchased without a prescription and may still be reimbursed from any of these accounts.

The IRS has also determined that debit card systems that are often used in conjunction with these programs are not capable of substantiating compliance with this new requirement because they are incapable of recognizing and substantiating that the drugs were prescribed. Therefore, debit cards cannot be used to purchase OTC drugs on or after January 16, 2011. While the rule prohibiting reimbursement for OTC drugs and medicines is effective on January 1, 2011, the IRS will not challenge the use of debit cards for expenses incurred through January 15, 2011, if the debit card is used in conformity with current regulatory requirements. This short 15-day “grace period,” however, may not provide much useful relief.

On or after January 16, 2011, OTC drugs can only be reimbursed if the pharmacy receipt, or other evidence of purchase, submitted to support the claim, contains: (i) the name of the purchaser or person for whom the prescription was written, (ii) the name of the drug, (iii) date and amount of the purchase, and (iv) a prescription number (or a copy of the prescription is also submitted). Debit cards may still be used at pharmacies that meet the 90% test (i.e., 90% or more of their gross receipts in the prior year consisted of items that qualify as medical care expenses under IRC § 213(d)), and proper substantiation is provided.

Because cafeteria plans that have allowed reimbursement for OTC drugs and medicines will need to be amended, the IRS is creating an exception to its “no retroactive amendments” rule, and will allow plans to be amended retroactively to January 1, 2011 (or January 15, 2011 for debit card purchases) for a period that extends to June 30, 2011.

Action Steps

An employer that sponsors a mini-med plan should consider whether it can show the requisite basis for obtaining a waiver, and, if so, apply for it. The employer also should contact its insurer to determine if the insurer is applying for the waiver for the policy governing the employer’s mini-med plan.

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Plan sponsors also will have to amend their cafeteria plan's health care FSA provisions to address the limitation on reimbursement for OTC drugs and modify any debit card provisions as well. They should also check with their FSA claim administrators to ensure that they have taken the necessary steps to administer these benefits properly and to determine if there are any changes needed in the administrative service agreements (ASAs).

TPAs of health care FSAs also will have to modify their systems and procedures to ensure that only properly prescribed and substantiated OTC drug purchases are reimbursed. In addition, TPAs should consider whether their ASAs need to be revised in any way.

If you have any questions about this new guidance and how it applies to your medical and cafeteria plan arrangements or your TPA business, or if you have questions about other aspects of ACA compliance or any other employee benefit issues, please contact any of the Honigman attorneys listed in this Alert.

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