

EMPLOYEE BENEFIT ADVISOR

Quarterly Newsletter

October 2009

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As always we welcome your comments and suggestions regarding this issue of Employee Benefit Advisor. For more information on this publication or on articles or information contained within this publication, please contact your Sales Representative, Account Manager or visit the Mourad Agency web site at www.aemourad.com.

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NEWS & VIEWS

Group Health Plans Compliance Items:

Several important changes in governing law and regulations during the past year require changes to group health plans in the upcoming open enrollment period.

Changes Required in 2009 or 2010

1. Mental Health Parity Act

For plan years beginning after October 3, 2009 (the later of January 1, 2010 or expiration of the governing collective bargaining agreement in force on October 3, 2008 for collectively bargained plans), a group health plan that provides mental health and substance abuse benefits cannot impose special caps or limits on benefits related to mental health treatment or substance use disorders.

Treatment limits and cost sharing, including deductibles, co-pays, co-insurance and out-of-pocket expenses, cannot be more restrictive than the most common or frequent rules that apply to substantially all medical and surgical benefits provided under the plan. If a plan offers out of network benefits for medical and surgical coverage, out of network benefits must also be offered for mental health and substance disorders.

A plan may not be required to comply with the new requirements if the plan complies for the first six months of a plan year and the increase in cost exceeds 2% of plan costs for the first year or 1% in subsequent years.

2. Michelle's Law

In plan years beginning after October 9, 2009 (January 1, 2010 for calendar year plans), a group health plan cannot terminate coverage for a dependent college student on account of loss of full-time student status due to a medically necessary leave of absence for up to one year. The plan must furnish information about Michelle's Law in any notice regarding certification of student status required for continued coverage under the plan.

3. COBRA Subsidy / ARRA Act of 2009

The American Recovery and Reinvestment Act of 2009 ("ARRA") provided a subsidy for COBRA premiums to "assistance eligible individuals" who are involuntarily terminated and lose group health coverage. Employers were required to update their COBRA election notices and forms to contain information on the subsidy. Employers should continue to use these special COBRA notices and election forms for individuals who both: (1) experience qualifying events on or before December 31, 2009; and (2) lose coverage on or before December 31, 2009. If the COBRA subsidy is not extended by new legislation, employers may resume using their pre-ARRA COBRA notices and election forms when an individual experiences a qualifying event or loses group health coverage on

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January 1, 2010, or later. The Department of Labor has model COBRA notices available.

Healthy Families Act

Employers should be aware of the Healthy Families Act of 2009 (HFA) that was introduced in the House of Representatives earlier this year. It seeks to guarantee full-time employees 56 hours of paid sick leave each year to address their own health needs and the health needs of their families. Part-time employees would receive a pro-rata amount of leave. This federal legislation would apply to employers with 15 or more employees and would guarantee them one paid hour off for each 30 hours worked. Unused sick leave could be carried over from one year to the next. This leave would be in addition to any leave provided under the Family and Medical Leave Act (FMLA) or a state's workers' compensation law. Employers would have to amend their existing leave policies to make sure that they meet the requirements of the HFA.

While this legislation has a long way to go before enactment, and may face many changes along the way, employers should keep their eye on it.

LEGISLATIVE INSIGHT

IRS Issues Information Letter on Over-the-Counter Medical Expenses

On July 14, 2009, the Internal Revenue Service (IRS) issued an information letter regarding reimbursement of certain over-the-counter (OTC) items by health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs). Specifically, the letter provides guidance on whether these items qualify as "medical care" expenses that may be reimbursed. The IRS notes in the letter that it is intended for informational purposes only and does not constitute a ruling by the IRS.

Medical Care Expenses

In the letter, the IRS explains that medical care expenses are amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting a structure or function of the body. Expenses for OTC items may qualify as medical care only if they are "primarily for" the prevention or alleviation of a physical or mental defect or illness. Expenses that merely benefit general health, on the other hand, are considered to be only personal expenses and will not qualify as medical care expenses.

Medical Care Factors

Whether an otherwise personal expense is primarily for medical care is a question of fact. Several objective factors may be considered in making this determination, including:

- The motive or purpose for making the expenditure;
- Whether a physician has diagnosed a medical condition and recommended the item as treatment;
- The link between the treatment and the illness;
- Treatment effectiveness; and
- The proximity in time to the onset or recurrence of a disease.

The "But For" Test

For the expense to be deemed medical care, it must be established that the expense would not have been paid "but for" the disease or illness. That is, the item is not for medical care if the individual would have paid for it even without a medical condition.

Personal and Medical OTC Items

The IRS letter specifically addresses a number of items that may be both personal and medical in nature, as well as items that are generally used only for medical care.

Personal Items as Medical Care

Certain items may qualify as medical care, or may be personal items, depending on how they are used. For example, a person may use these items to maintain general health, or as toiletries or cosmetics. These are personal uses. However, if it can be shown that the item is used to treat or alleviate a disease or injury, and satisfies the "but for" test, the item may qualify as a medical care expense.

These items include:

- Sunscreen;
- Medical grade face masks;
- Skin products;
- Anti-bacterial hand sanitizers;
- Fluoride rinses;
- Petroleum jelly;
- Fiber supplements; and
- Probiotics.

Medical Care Only Items

Items that have no purpose other than to treat a disease, illness, or mental or physical defect may qualify as medical care. Treatments for the following conditions will most likely qualify as medical care:

- Acne;
- Incontinence;
- Arthritis;
- Constipation;
- Colds and sinus problems;
- Dehydration; and
- Indigestion.

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In addition, the following items will probably qualify as medical care:

- Support braces and shoe inserts for injured or weakened body parts;
- Products that have no purpose but to treat existing skin conditions such as eczema (as opposed to products that are designed to prevent the development of the condition); and
- Wheelchair cushions that are a necessary accessory to a wheelchair.

Excess Cost of Personal Items

The excess cost of an otherwise personal item that is specially designed to treat or alleviate a medical condition, over the cost of the item without the special features, may be considered an expense for medical care. For example, the cost of specially designed clothing that is used to treat a specific disease, such as diabetic socks, compression hose or orthopedic shoes, that exceeds regular clothing may be a medical care expense. However, these items may also be used for personal or preventive reasons. Whether they are eligible for reimbursement will depend on the facts of each specific case.

Food and Food Thickeners

The cost of food is not a medical care expense if it is a substitute that a person would normally consume to meet nutritional requirements. However, it is possible that food thickeners may be considered a medical care expense. This is a question of fact that must be determined on a case-by-case basis.

RX CORNER

Nonprescription Medical Expenses

Today, many employers offer a health flexible spending account (FSA), Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) to their employees. Health FSAs, HSAs and HRAs may allow employees to use pre-tax money to pay for medical expenses. IRS rules govern what medical expenses may be reimbursed through a health FSA, HSA or HRA. Traditionally, the IRS had held that expenses for medicine or drugs were eligible for reimbursement only if they required a physician's prescription. The IRS later revised its approach to permit reimbursement for over-the-counter medications as well.

Are Nonprescription Drugs Reimbursable Under a Health FSA, HSA or HRA?

Yes. In 2003, the Internal Revenue Service (IRS) and Treasury Department released Revenue Ruling 2003-102. This guidance clarified that the cost of nonprescription drugs are eligible for reimbursement from a health FSA or HRA. Subsequent guidance extended this rule to HSAs as well. The IRS ruling states that medical expenses incurred for the purpose of treating, mitigating, curing, or

preventing disease are reimbursable. However, expenses that are merely beneficial to the general health of an individual are not eligible. For example, expenses for dietary supplements are not eligible.

What nonprescription drugs are reimbursable?

Nonprescription drugs that the IRS has approved for reimbursement include the following:

Antacids,
Allergy medicine,
Pain relievers, and
Cold medicine.

Other types of medications or items used for medical care may be reimbursable if they meet the guidelines set forth by the IRS in its ruling. For example, the IRS has indicated in an information letter issued in July 2009 that certain personal items, such as medical grade face masks or skin products, may be reimbursable if they meet the guidelines. The IRS also ruled in Revenue Ruling 2007-72 that over-the-counter diagnostic devices or procedures, such as pregnancy tests, are also reimbursable by health FSAs, HSAs and HRAs.

Is a plan amendment necessary to reimburse nonprescription drugs?

The IRS merely defines what medical expenses may be reimbursable under a health FSA, HSA or HRA. While a plan may not be more generous than allowed by the IRS, it may choose to limit to a greater extent what expenses are reimbursable under its plan. If the plan document states that it will provide reimbursement for all medical expenses as allowed by the IRS, it may follow this guidance with no additional amendments necessary. If the plan document specifically excludes nonprescription drugs, a plan amendment is necessary before these expenses are eligible for reimbursement.

To view a copy of Revenue Ruling 2003-102, visit http://www.irs.gov/irb/2003-38_IRB/ar08.html. To view a copy of Revenue Ruling 2007-72, visit http://www.irs.gov/irb/2007-50_IRB/ar06.html.

BLUE CROSS UPDATES & CHANGES

BCN, Sparrow agree on BCN acquiring Physicians Health Plan of Mid-Michigan membership

Blue Care Network has reached an agreement with Sparrow Health System to purchase the membership of Lansing-based Physicians Health Plan of Mid-Michigan. It's anticipated that the transaction, which still requires regulatory approval from the state Office of Financial and Insurance Regulation, will be completed before the end of

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2009. Physicians Health Plan of Mid-Michigan is a Lansing-based health plan with close to 80,000 members, including approximately 18,000 Medicaid HMO members. The Medicaid transaction will require approval from the Michigan Department of Community Health.

This transaction provides value to PHP and BCN customers by spreading administrative costs across expanded membership, helping keep health care costs affordable and offering long-term value to customers, members and participating providers. It also allows Sparrow Health System to focus on its core services of providing quality, compassionate health care to the Mid-Michigan communities

There are no immediate changes for PHP Mid-Michigan groups as a result of the announcement and as the sale moves through the regulatory process. PHP Mid-Michigan members can continue to receive their PHP coverage, use their PHP ID card, visit their PHP network physician and contact their same customer service number. PHP Mid-Michigan physicians can continue to send health care claims for PHP members in their normal manner.

Following completion of the transaction, BCN is committed to providing a smooth transition to BCN for PHP Mid-Michigan members and customer groups. PHP Mid-Michigan groups will receive extensive communications from BCN prior to transitioning coverage so BCN can match them with the BCN products that best fit their needs. Transition is likely to begin in the first half of 2010 and will be in conjunction with group renewal dates to the greatest extent possible. BCN is committed to offering an excellent array of benefits, network of providers and services.

The organizations pledge to make the transition as seamless as possible and to maintain a high level of service to members, customers and providers.

Important News for Subscribers with Dependents

Blue Cross Blue Shield of Michigan and Blue Care Network are preparing for their annual dependent audit for dependents. In October 2009, you can expect to receive Blue Cross Blue Shield of Michigan's annual notice of subscribers who have dependents who have reached 19 or 25 years old. If you have dependents between the ages of 18 and 30, they may be eligible for BCBSM's Young Adult BlueSM plan.

Young Adult Blue costs **less than \$50 a month** and provides inexpensive catastrophic coverage and includes the Affinity Rx discount prescription drug program.

If your employees are interested in this coverage please direct them to www.mourad.coverageforone.com or contact your Account Manager.

LIVE WELL, WORK WELL



H1N1 (formerly called swine flu) remains a threat, but scientists have worked hard to develop an effective vaccine. Here is the latest information regarding the H1N1 vaccine:

When?

U.S. officials are predicting that the vaccine will be available by late October 2009. The World Health Organization (WHO) has assured the public that the vaccine is completely safe, despite the quicker than usual timeline of development and approval. It is currently undergoing clinical trials.

How Many Shots?

Though experts had previously predicted the necessity for two H1N1 vaccination shots, clinical trials are now showing that the vaccine protects with only one dose. However, this is in addition to the normal seasonal flu shot, so people will need to get two separate shots to protect against both seasonal and novel H1N1 flu. Seasonal flu shots are already becoming available in most areas.

Priority Recipients

It is likely that there will be limited quantities of the H1N1 vaccine, at least initially. Therefore, the Centers for Disease Control's Advisory Committee on Immunization Practices recommends these priority groups for receiving the vaccination first:

- Pregnant women
- People who live with or care for children younger than six months old
- Healthcare and emergency medical services personnel
- Persons between six months and 24 years old
- Persons ages 25-64 who are at higher risk for novel H1N1 due to chronic health disorders or compromised immune systems

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United Healthcare to Cover H1N1 Flu Vaccine for its Members

As you may have read, all regions of the U.S. have now reported positive cases of the H1N1 flu. The latest comments from the Centers for Disease Control and Prevention (CDC) suggest the situation remains fluid.

United Healthcare will provide coverage for the administration of the H1N1 (swine flu) vaccine for all members covered by its fully insured plans.

They intend to process all self-funded member claims as a covered service unless clients explicitly direct them otherwise. If your plan does not currently cover the administration of the vaccine, and you notify them of your intent not to cover the vaccine in the future, United Healthcare will reimburse the cost of the administration of the vaccine. The federal government has said that the vaccine will be provided at no cost to health care providers.

Based on its analysis of the current situation, The CDC's Advisory Committee on Immunization Practices has recommended prioritizing the following population segments to receive the vaccine:

- pregnant women;
- caregivers for children younger than 6 months of age;
- health care and emergency medical services personnel;
- children and young adults from 6 months through 24 years old; and
- persons aged 25 through 64 years who have underlying health conditions that might increase their risk for flu-related complications.

Other population segments will be able to receive the vaccine, as it is made available.

PRODUCT



Home Mortgage Negotiators of America (HMNA) is a consumer advocacy firm that specializes in providing individuals and families a unique solution to mortgage affordability concerns. We provide a piece-of-mind service by negotiating with our customers current mortgage company or bank to help them reduce their monthly payment, obtain a more favorable interest rate, improve their loan terms, and even reduce their principal balance.

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- Increase corporate productivity and profitability by reducing their worrisome debt.
- Reduce absenteeism due to personal financial issues.
- Promote better attitudes with colleagues and customers.

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