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INSURANCE BRIEF

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Health Care Reform in the Courts

The Sixth Circuit was the first to uphold the constitutionality of the individual mandate provision in June. The challengers in that case have already appealed to the U.S. Supreme Court. The Fourth Circuit ruled on September 8th that the plaintiffs in their case lacked legal standing and the judges did not even address the issue of constitutionality. Rather than appeal a lower court ruling in Cincinnati, lawmakers in Ohio put an Amendment to invalidate the health care mandate on the statewide ballot for November . A fourth challenge to the law was heard on September 23rd by the U.S. Court of Appeals for the District of Columbia Circuit. A ruling is pending.

September 26th the Obama Administration declined to file an appeal with the 11th Circuit Court in Atlanta over the Florida ruling that the individual mandate is unconstitutional. Instead the administration appealed directly to the U.S. Supreme Court on the 28th and asked the justices to schedule the case during the 2011-12 term which ends in June. The hope is that they will receive a favorable ruling prior to the 2012 elections. Adding to the pressure on the Supreme Court to rule on the constitutionality of the law, the 26 states which sued to overturn the law filed an appeal with the Supreme Court on September 28th. It could be January before the Court decides whether to hear the case.

Special Foods as Medical Expense

The Internal Revenue Service (IRS) has released an information letter on the question of when special foods can qualify as a medical care expense under IRC Section 213(d). Information letters are not binding, but it provides insight into the IRS' current thinking. The contents may be helpful in determining whether certain costs qualify under a health FSA, HRA or HSA.

In the letter the IRS states that medical care refers to amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting the structure or function of the body. (Section 213(d)(1)(A)).

Among the objective factors that indicate that an otherwise personal expense is for medical care are the taxpayer's motive or purpose for making the expenditure, whether a physician has diagnosed a medical condition and recommended the item as treatment or mitigation, linkage between the treatment and the illness, treatment effectiveness, and proximity in time to the onset or recurrence of a disease. If the taxpayer would have paid the expense even in the absence of a medical condition then it is not deductible as medical care.

The excess cost of specially prepared foods designed to treat a medical condition over the cost of ordinary foods which would have been consumed but for the condition is an expense for medical care. If a taxpayer can establish the medical purpose of the diet, such as through a physician's diagnosis, then to the extent the cost of the food for the special diet exceeds the cost of the food that satisfies a taxpayer's normal nutritional needs if the special diet were not required, the excess cost is an expense for medical care under section 213(d).

Medicare Part D Notice Reminder

It's that time of year again!! The Centers for Medicare and Medicaid Services (CMS) requires entities to provide an annual notice to Part D eligible individuals before October 15, 2011 indicating whether its plan's coverage is creditable or non-creditable. The Disclosure Notice requirement applies to Part D eligible individuals who are *active or retired* employees, as well as those who are covered as spouses or dependents under active or retiree coverage.

If your plan data does not include dependent data in the detail necessary to identify eligible dependents who may be Medicare Beneficiaries, you may choose to provide the notice to all eligible employees to assure proper notice to all Medicare Beneficiaries. Notice to the employee will constitute notice to dependents unless you have a separate address for a non-resident spouse/dependent.

Plan Sponsors must also provide a Medicare Part-D notice:

a. Prior to an individual's Initial Enrollment Period for Part-D;
b. Prior to the effective date of coverage for any Medicare eligible individual that joins the Plan;
c. Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and,
d. Upon the request by the individual.

"Prior to" means that the individual must have received the Disclosure Notice within the past twelve months. So, plans that issue the Part-D notice at time of policy renewals do not need to provide another notice.

The notices were updated April 2011 and are provided in English and Spanish at http://www.cms.gov/CreditableCoverage/Model%20Notice%20Letters.asp#TopOfPage. You can also contact your SML Account Team to request a copy be emailed to you.

Disclosure to CMS Form. Don't forget that you must also disclose to CMS whether your plans' coverage is creditable or non-creditable. This is done online at www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp

This disclosure must be made within 60 days following the start of the plan year, within 30 days after termination of a prescription drug plan, and within 30 days after any change in the plan's creditable coverage status.

2012 SF HCSO Expenditure Rates

The San Francisco Office of Labor Standards Enforcement has released the 2012 health care expenditure rates.

- Large employers with 100+ employees: $2.20/hour
- Medium employers with 20-99 employees: $1.46/hour
- Small employers with 1-19 employees are exempt as are non-profits with fewer than 50 employees.

The 2012 Annual Salary Exemption Figure has not been released yet. A covered employee continues to be one who is working 8 hours per week on average in San Francisco. For current forms and other useful information see their website.

Comparative Effectiveness Research Fee

The Patient Protections and Affordable Care Act (PPACA) provides for a temporary fee to fund comparative effectiveness research (CER). The CER fee will be imposed on both health insurers (in the case of fully-insured) and plan sponsors of self-insured health plans. Exempt from the fee are "excepted benefits" as defined under HIPAA. These include stand-alone vision and dental coverage as well as HRAs and most FSAs. In the unusual case of an FSA offered without other group health plan benefits, then the fee would apply. The fee will apply to stand-alone retiree health plans that are not otherwise an "excepted benefit."

Effective Date: The fee applies for each plan year (policy year in the case of fully-insured plans) ending after September 30, 2012, but does not apply for policy or plan years ending after September 30, 2019. For example, a self-insured plan with a calendar plan year will pay the fee for plan years 2012 through 2018. For fully-insured policies, the fee begins for policy year November 1, 2011 to October 30, 2012. It will end with the October 1, 2018 to September 30, 2019 policy year.

For the first year the fee is $1 multiplied by the average number of covered lives. This includes dependents. The rate of the fee increases to $2 for the next year and is indexed thereafter. In IRS Notice 2011-35 comments were requested on reasonable methods that may be used to determine the number of lives covered. The Notice indicates that future proposed regulations could require the fees be paid annually as opposed to quarterly. In addition, reporting and payment may be on the same calendar date regardless of the applicable policy year or plan year. Comments were requested on this approach.

Background: As required by PPACA the nonprofit Patient-Centered Outcomes Research Institute was established to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing clinical effectiveness research. PPACA includes provisions that promote research to evaluate and compare health outcomes and the clinical effectiveness, risks, and benefits of medical treatments, services, procedures, drugs, and other strategies or items that treat, manage, diagnose, or prevent illness or injury.

PPACA added a new section to the Internal Revenue Code to establish the Patient-Centered Outcomes Research Trust Fund to fund the Patient-Centered Outcomes Research Institute. The Trust is to be funded in part by fees to be paid by issuers of health insurance policies and sponsors of self-insured health plans.

What's Next: The Department of the Treasury and the IRS will publish proposed regulations implementing and providing guidance on the statutory requirements applicable to insurers and plan sponsors that pay those fees.