

TAXSAVER PLAN

"Your Satisfaction Is Our Success"

WHAT YOU NEED TO KNOW...

OTC DRUGS & FSA'S FOR 2011

In March, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively "the Act"). The Act includes a number of modifications to employee benefit programs.

One provision that will affect your employee participants beginning January 1, 2011 is the requirement for over-the-counter (OTC) drugs, medicines and biologicals to be accompanied by a physician's prescription in order to be reimbursed under health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) and health savings accounts (HSAs). Below is a summary of this change and how it will impact plans and the participants' experience.

CHANGES TO OVER-THE-COUNTER ELIGIBILITY FOR REIMBURSEMENT

Under the Act, OTC drugs, medicines and biologicals will continue to be eligible for reimbursement as long as the request is accompanied by a Medical Determination Letter or doctor's prescription. This means items such as cough medicines, pain relievers, acid controllers, and diaper rash ointment will now require a doctor's prescription to be submitted along with the reimbursement request. Insulin and other OTC items, such as band-aids, contact lense solutions will continue to be eligible without a prescription.

Since this change applies to all expenses incurred on or after January 1, 2011 it will affect all plans and participants at the same time, regardless of the plan year.

OTC drug expenses incurred on or after January 1, 2011 will require a doctor's prescription in order to be reimbursed under a health FSA, HRA or HSA. Expenses incurred prior to January 1, 2011 will not. For example, for a calendar year plan with a claim-it-by date of March 31, 2011, an OTC drug purchased on December 31, 2010, could be submitted before a plan's claim-it-by date of March 31, 2011, and still be reimbursed without a prescription.

This provision will also impact the use of all heath care debit cards. Beginning January 1, 2011, merchants who are IAS certified will need to modify the list of items eligible for payment. This is because of the doctor's prescription requirement. Purchases of OTC

drugs, medicines and biologicals will require another form of payment and then the employee can electronically submit a paper claim along with a Medical Determination Letter or doctor's prescription for the OTC drug, medicine or biological purchased. This change affects only OTC drugs, medicines and biologicals - bandages, contact lense solution, home health-aids and other OTC items will still be eligible and can be purchased using the card without further documentation.

It is our objective to create a simple solution for participants to obtain the proper documentation and be able to easily submit these OTC expenses. We are currently working on this project.

Taxsaver Plan will begin to communicate this information to participants via email and reimbursement stuffers in early November. If Taxsaver Plan does not prepare your open enrollment communication piece, please be sure to include in your open enrollment material for 2011 plan years.

NON-DISCRIMINATION TESTING...IT'S THAT TIME OF YEAR AGAIN.

Code Section 125 of the IRC requires that Plans test for non-discrimination. This has been a part of the regulation since inception. Because the regulations have always been proposed versus final, many employers felt it was not necessary to test. However, it is the responsibility of the Plan Sponsor to operate the plan with the proposed regulation in mind.

There are various tests to be performed. First there are test for the Section 125 Plan itself. Secondly, there are underlying test for the various plans under the umbrella of the Section 125 Plan. These would normally include the Health Spending Account, the Dependent Care Assistance Program and the Health Plan if it's self funded.

The purpose of all testing is to determine if the Plan discriminates. A Plan can not discriminate in favor of the highly compensated employee (HCE) both in terms of eligibility and benefits. Who are these HCEs? Well, that is somewhat of a problem because they vary as to definition in each Plan. Once they are separated into their respective groups, then you test each plan as to eligibility, benefits and utilization. One can compare these tests to inviting guests to a party.

The first test is to determine who you invite, then of those invited what did you offer each to eat, and lastly what they actually ate while there.

Testing a normal Section 125 Plan with both a health spending account and a dependent care account plan comprises eleven tests.

The overall Section 125 Plan is tested as to:

- Eligibility
- Contribution and Benefits
- Key Concentration

The Health FSA is tested as to:

Eligibility
Benefits

The Dependent Care Plan is tested as to:

Eligibility
Contribution and Benefits
More than 5% Owner Concentration Test
55% Average Benefit Test

Self Funded Medical Plan is tested as to:

Eligibility
Benefits

There is a new Safe Harbor test for Premium Only Plans (POP).

The proposed regulations never addressed when the test need to be preformed. The proposed final regulations state that the Plan must be tested on the final day of the plan. Regardless, TSP recommends that test be preformed by mid plan year so that corrections can be made to bring the plan into compliance.

If you have not contacted Tax saver Plan for information about testing, please contact Kelsey for file specifications.

Thank You,

Charles Zelazny
President

Kelsey Zelazny
Vice President

Marsha Hooper
COO