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REFORM Update

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The Department of Labor (DOL), Department of Health and Human Services (DHHS) and the Internal Revenue Service (IRS) recently published a set of frequently asked questions (FAQs) on a host of health care reform requirements. This *Update* reviews the issues addressed in the FAQs.

Exchange Notice Requirement

Employers must notify their employees of the new health Exchanges. Specifically, the notice needs to:

1. Inform employees the Exchanges exist, describe the services they provide, and include contact information.
2. Inform employees if the employer-sponsored plan has less than a 60 percent value. In that case, employees may be eligible for tax credits when they purchase individual coverage through the Exchange.
3. Tell employees that the employer does not pay for coverage obtained through the Exchange. Also, if the employer sponsors and pays part of the health plan cost, employees need to know they will lose that subsidy if they are covered through the Exchange. In addition, there may be tax consequences. Individually purchased health insurance, unlike employer-sponsored coverage, is generally taxed.

Employers were initially required to send this notice by March 1, 2013. The FAQs delay this effective date for several reasons:

1. The notice should be coordinated with DHHS educational efforts, which are expected in late summer or early fall.
2. The IRS has not yet released guidance on how to determine the minimum value of employer-sponsored health plans.
3. The Departments want to provide employers with adequate lead-time.

It makes sense to delay this notice deadline. The new date will be closer to the time when the Exchanges open for business (October 1, 2013). The Departments expect to publish the distribution date that will be in late summer or early fall.

The Departments may develop a generic notice that employers can use as a model. Otherwise, employers can use the template available on the Exchange website.

Application of Annual and Lifetime Limits to Health Reimbursement Arrangements (HRAs)

HRAs are self-funded medical plans that cover certain health expenses. Typically, HRA benefits are specific dollar amounts set annually. Plans may allow unused funds to roll over into the next plan year.

Since these plans are considered employer-sponsored medical plans, they must comply with health care reform requirements. Some HRAs will not be able to meet the restriction on annual dollar limits. This requirement has been phased in over a three-year period, but HRAs have a waiver until 2014.

HRAs are commonly part of a comprehensive health plan. For example, an employer may purchase a $3,000 deductible plan, and then establish an HRA with a $2,500 benefit. The result is the employee has a $500 deductible for the medical plan. If the HRA is integrated with a health plan meeting the requirements for annual and lifetime dollar limits, then the HRA does not violate the rules.

The FAQs discuss two situations where HRAs will not be permitted. First, an employer-sponsored HRA cannot be integrated with an employer plan providing health plan coverage through individual policies. Second, an HRA will not be considered integrated if the employee does not enroll in the underlying health plan. For employers that were planning to offer premium–only to ***active*** employees, this will not be permitted in 2014. Premium-only HRAs can still be used an option for retiree medical coverage. HRAs coordinated with employer–sponsored comprehensive health coverage will still be permitted. The underlying employer–sponsored plan must not apply annual or lifetime dollar limits on essential health benefits.

The FAQs also discuss grandfathering amounts credited to an HRA before January 1, 2014. Those amounts can be used to reimburse medical expenses after December 31, 2013, whether the HRA is integrated or not. However, contributions must accumulate under certain rules. First, the 2013 contributions must be credited according to the plan's terms as of January 1, 2013. If the plan does not specify how contributions will be credited in 2013, then the credited amounts cannot exceed amounts credited in 2012. In this situation, the 2013 contributions cannot be credited at a faster rate than in 2012.

This provision allows employees to keep the money that has accumulated in an HRA if that plan stops being funded in 2014. The accumulation rules protect against situations where the HRA contributions would have been dramatically increased to allow significant rollovers that could be used well beyond 2014. The Departments anticipate issuing additional guidance on this situation.

Employer Group Waiver Plans (EGWPs)

The FAQs also discuss how health care reform applies to EGWPs, which offer Medicare Part D benefits and additional supplemental prescription drug benefits. An EGWP that covers only retirees is exempt from health care reform requirements. Some EGWPS insure standard Medicare Part D benefits through a policy issued to the employer. The employer then supplements that benefit with a self-funded plan. The self-funded supplemental benefit is considered an excepted benefit, and is therefore not subject to the health care reform requirements.

Provisions of Fixed Indemnity Plans Needed to Qualify as "Excepted Benefit"

Because traditional fixed indemnity plans are considered "excepted benefits," they do not need to comply with health care reform provisions. The Departments have now begun to notice a significant increase in the number of fixed indemnity policies being offered throughout the country. These plans typically pay a fixed dollar amount for each day of hospitalization, regardless of the actual cost.

These FAQs clarify that a hospital indemnity or fixed indemnity plan provides "excepted benefits" only if:

- A separate policy provides the benefits, certificate or contract of insurance.
- Group health plans maintained by the same plan sponsor do not coordinate or exclude benefits.
- The benefits are paid regardless of whether they are provided for the same event under a group health plan the same plan sponsor maintains.

The FAQs discuss "fixed indemnity plans" with plan designs that do not indicate such a plan. An example of non-conforming fixed indemnity plan includes all the following benefits:

- The plan covers $50 for an office visit.
- The plan covers hospitalization at $100 a day.
- The plan covers various surgical procedures with various fixed payments, based on a schedule.
- The plan covers prescription drugs at $15 for each prescription.

This type of plan provides a specific benefit based on the kind of service. It does not qualify as an indemnity plan because it is not paying a fixed amount for each day or for any other specific period of time. When a policy pays for a service rather than for a specific amount of time, then it is a form of health coverage, not income replacement. Such a plan would not be considered a fixed indemnity plan.

Payment of Comparative Effectiveness Research (CER) Fees by Multi-Employer Plans

Plans must pay CER fees as of their first plan year ending on or after October 1, 2012. The latest guidance on CER fees can be found in our Reform Update at http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_58.pdf.

The FAQs discuss who may pay the CER fees for multi-employer plans. The plan sponsor considered liable for CER fees for a multi-employer plan is generally the independent joint board of trustees. The board of trustees does not have a funding source to pay the CER fees, except for plan assets. The FAQ confirms that in this situation, and for certain retiree-only voluntary employee benefit arrangements (VEBAs), the CER fees may be paid from plan assets.

This rule does not, however, apply to other plan sponsors required to pay the fees. A group or association of employers that acts as a plan sponsor (but also exists for reasons other than

sponsoring a health plan) cannot pay the CER fees from plan assets. This is the case even if the association of employers funds the benefit plan through a VEBA.

Concluding Thoughts

This information answers the most commonly asked questions on specific health care reform issues. The delayed deadline for the Exchange notice was expected, because the original March effective date was too far in advance of when the Exchanges would be ready for inquiries. It makes more sense to release this information closer to the time the government launches the Exchanges.

As 2014 approaches, expect more of these FAQs as stakeholders move forward on complying with health care reform requirements.