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ATTORNEYS

Health Care Reform Management Alert Series

New Guidance Delays Effective Date for Employer Exchange Notification — Issue 50

This is the fiftieth issue in our series of alerts for employers on selected topics in health care reform. (Click here to access our general summary of health care reform and other issues in this series) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Department of Labor released a new set of Affordable Care Act FAQs on January 24, 2013, delaying the effective date for the employer exchange notice requirement and providing other useful guidance.

Delayed Effective Date for Exchange Notice

The Affordable Care Act requires all employers who are subject to the Fair Labor Standards Act to issue a notice to employees regarding the exchanges no later than March 1, 2013. (*Note* -- this requirement applies to employers rather than to plan sponsors, meaning it would not apply directly to multiemployer plans, but it could apply to contributing employers.) The notice must provide:

- A description of the state health insurance exchanges (Exchanges), including contact information for the Exchanges;
- A statement that employees may qualify for a tax credit to help pay for Exchange coverage if the employer's plan does not provide minimum value (i.e., if the plan's share of benefit costs does not equal or exceed 60% of the actuarial value of coverage); and
- A statement regarding the financial and tax consequences of purchasing coverage through the Exchanges (i.e., that the employee will forego the employer-paid portion of the premium (if any) and tax exclusion for the employer-sponsored coverage).

The DOL FAQs delayed the effective date of this requirement to a date at some point in the near future, likely during the late summer or early fall of 2013. The delay serves two purposes:

1. It will allow the DOL more time to develop a model notice, and
2. It will align the effective date with the first open enrollment period for the Exchanges.

Other Useful Guidance On HRAs, Medicare Part D, Fixed Indemnity Insurance and PCORI Tax

The FAQs also included a hodgepodge of other useful guidance, as detailed below.

Stand-Alone HRAs Prohibited When Paired with Individual Insurance Policy

Prior Rule

- The Affordable Care Act generally prohibits group health plans from imposing lifetime and annual dollar limits on benefits. For more information on this rule, click *here*.
- Special rules apply to health reimbursement arrangements, or HRAs, which are considered group health plans and, by their very nature, constitute an annual dollar limit on benefits (because a participant may never be reimbursed for benefits in excess of his or her HRA account balance).
- Stand-alone HRAs covering active employees are generally prohibited, but the DOL delayed the effective date of this prohibition until 2014.
- But, certain HRAs are permanently exempt from the dollar limit prohibition if (1) they are part of a retiree-only plan, or (2) they are integrated with other major medical coverage.

New Guidance

- The FAQs provide that an HRA will not be considered "integrated" if it is paired with an individual insurance policy. It must be paired with group health coverage; otherwise it is prohibited starting in 2014.
- The prohibition on stand-alone HRAs applies even if the employee was offered group health coverage but declined. In other words, no employee may be covered by an HRA unless he or she was also offered and accepted major medical coverage.
- The FAQs contain a special "spend-down" rule that allows participants to exhaust their accumulated balance in a stand-alone HRA after 2013. It also contains a special rule limiting how much can accumulate to an HRA account during the 2013 calendar year.

Self-Insured Supplemental Benefit to EGWP Not Subject to Health Coverage Requirements	
Prior Rule	**New Guidance**
• The Affordable Care Act imposes a number of new requirements on group health plans, including the adult child coverage requirement, the preventive care services requirement, and the prohibition on lifetime and annual dollar limits. These rules do not apply to retiree-only plans or certain "excepted benefits" (such as stand-alone dental or vision coverage). • However, retiree prescription drug coverage is still subject to these health coverage requirements, *if* the coverage is part of the same "group health plan" as active employees. • This means that prescription drug coverage provided to retirees that is intended to supplement EGWP coverage[1] would technically be subject to the all of the new health coverage requirements listed above (even if the coverage doesn't provide major medical benefits).	• The FAQs indicate that the DOL will not take enforcement action for failure to comply with these new health coverage requirements against self-insured retiree prescription drug coverage that is intended to supplement an EGWP (even if that coverage is part of a broader plan that also covers active employees). • The FAQs indicate that CMS will issue supplemental guidance addressing fully-insured prescription drug coverage that is intended to supplement an EGWP. • The guidance does not address whether the DOL will take such enforcement action against a traditional retiree prescription drug plan that otherwise qualifies for the Medicare Part D subsidy (i.e., the alternative to providing retiree drug coverage through an EGWP). It remains unclear whether sponsors of this type of coverage should attempt to comply with the health coverage requirements. • This guidance is consistent with the general relaxed enforcement efforts toward retiree coverage, which seems designed to encourage employers to continue offering such coverage in an era where retiree welfare benefits are becoming less common.

[1]The government created a subsidy program to incentivize employers to continue offering prescription drug coverage to retirees in the wake of the new Medicare Part D entitlement program (i.e., the Medicare prescription drug benefit program). Generally speaking, employers can take advantage of this incentive in one of two ways: (1) offer prescription drug coverage that is at least as generous as Part D coverage and receive a subsidy to help offset the cost of that coverage, or (2) create a plan known as an Employer Group Waiver Plan (or EGWP), which is akin to an insured prescription drug program. Employers sometimes supplement Medicare Part D coverage provided through an EGWP with additional non-Medicare drug benefits.

Narrowed Definition of Fixed Indemnity Policies	
Prior Rule	**New Guidance**
• As discussed above, certain "excepted benefits" are exempt from most of the health coverage requirements in the Affordable Care Act. • One example is "fixed indemnity coverage," which is a type of insurance policy that only pays a fixed dollar amount per day (or per period) for hospitalization or illness. An example would be an insurance policy that pays an individual $100 for each day that he or she is in the hospital. • To qualify for the exemption, the policy must pay out regardless of the benefits offered in any underlying medical plan or policy (i.e., there can be no coordination of benefits between the fixed indemnity policy and the major medical coverage).	• The FAQs indicate that the agency has become aware that issuers of health policies are exploiting this exception by labeling products as fixed indemnity insurance that would otherwise not qualify. • As a result, the DOL will work with state agencies to step up enforcement efforts when it comes to improperly characterized fixed indemnity policies. • The FAQs suggest that to qualify for the exemption, the policy must provide payment on a per-day (or per-period) basis, rather than providing a varying payment depending on the type of benefit received or doctor visited. For example, a policy that pays different amounts depending on the type of surgical procedure performed would not qualify as a fixed indemnity insurance policy.

Multiemployer Plan Sponsors May Pay PCORI Tax from Plan Assets

Prior Rule	New Guidance
• The PCORI tax is a new fee on group health plan sponsors amounting to $1 per covered life in the first year of applicability and $2 per covered life in subsequent years. For more background on the PCORI tax, click *here*. • Prior guidance indicated that the DOL would weigh in on whether multiemployer plan sponsors could pay the tax out of plan assets.	• The FAQs provide that multiemployer plan sponsors may pay the PCORI tax out of plan assets held in trust. • Note, though, that the DOL limited this rule to plan sponsors who exist solely for the purpose of sponsoring and administering a plan. • So, to the extent an organization (e.g., employer) sponsors a VEBA but also has another purpose, such as running a business selling widgets, the PCORI tax may not be paid out of plan assets. It must instead be paid from general corporate revenue.

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