

# FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XI)

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January 24, 2013

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of various provisions of the Affordable Care Act. These FAQs have been prepared by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/>), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

The Departments anticipate issuing further responses to questions and issuing other guidance in the future. We hope these publications will provide additional clarity and assistance.

## **Notice of Coverage Options Available Through the Exchanges**

Section 18B of the Fair Labor Standards Act (FLSA), as added by section 1512 of the Affordable Care Act, generally provides that, in accordance with regulations promulgated by the Secretary of Labor, an applicable employer must provide each employee at the time of hiring (or with respect to current employees, not later than March 1, 2013), a written notice:

1. Informing the employee of the existence of Exchanges including a description of the services provided by the Exchanges, and the manner in which the employee may contact Exchanges to request assistance;
2. If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the employee purchases a qualified health plan through an Exchange; and
3. If the employee purchases a qualified health plan through an Exchange, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

### **Q1: When do employers have to comply with the new notice requirements in section 18B of the FLSA?**

Section 18B of the FLSA provides that employer compliance with the notice requirements of that section must be carried out “[i]n accordance with regulations promulgated by the Secretary [of Labor].” Accordingly, it is the view of the Department of Labor that, until such regulations are issued and become applicable, employers are not required to comply with FLSA section 18B.

The Department of Labor has concluded that the notice requirement under FLSA section 18B will not take effect on March 1, 2013 for several reasons. First, this notice should be coordinated

with HHS's educational efforts and Internal Revenue Service (IRS) guidance on minimum value. Second, we are committed to a smooth implementation process including providing employers with sufficient time to comply and selecting an applicability date that ensures that employees receive the information at a meaningful time. The Department of Labor expects that the timing for distribution of notices will be the late summer or fall of 2013, which will coordinate with the open enrollment period for Exchanges.

The Department of Labor is considering providing model, generic language that could be used to satisfy the notice requirement. As a compliance alternative, the Department of Labor is also considering allowing employers to satisfy the notice requirement by providing employees with information using the employer coverage template as discussed in the preamble to the Proposed Rule on Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing (78 FR 4594, at 4641), which will be available for download at the Exchange web site as part of the streamlined application that will be used by the Exchange, Medicaid, and CHIP. Future guidance on complying with the notice requirement under FLSA section 18B is expected to provide flexibility and adequate time to comply.

### **Compliance of Health Reimbursement Arrangements with Public Health Service Act (PHS Act) section 2711**

Section 2711 of the PHS Act, as added by the Affordable Care Act, generally prohibits plans and issuers from imposing lifetime or annual limits on the dollar value of essential health benefits. The preamble to the interim final regulations implementing PHS Act section 2711 (75 FR 37188) addressed the application of section 2711 to health reimbursement arrangements (HRAs) and certain other account-based arrangements. HRAs are group health plans that typically consist of a promise by an employer<sup>1</sup> to reimburse medical expenses (as defined in Code section 213(d)) for a year up to a certain amount, with unused amounts available to reimburse medical expenses in future years. The preamble distinguished between HRAs that are "integrated" with other coverage as part of a group health plan and HRAs that are not so integrated ("stand-alone" HRAs). The preamble stated that "[w]hen HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2711, the fact that benefits under the HRA by itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies the requirements." (75 FR 37188, at 37190-37191). The corollary to this statement is that an HRA is not considered integrated with primary health coverage offered by the employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage provided by the employer and meeting the requirements of PHS Act section 2711.

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<sup>1</sup> An HRA may be sponsored by an employer, an employee organization, or both. For simplicity, this section of the FAQs refers to employers. However, this guidance is equally applicable to HRAs sponsored by employee organizations, or jointly by employers and employee organizations.

Questions 2 through 4 below address certain issues relating to HRAs. The Departments anticipate issuing future guidance addressing HRAs.<sup>2</sup>

**Q2: May an HRA used to purchase coverage on the individual market be considered integrated with that individual market coverage and therefore satisfy the requirements of PHS Act section 2711?**

No. The Departments intend to issue guidance providing that for purposes of PHS Act section 2711, an employer-sponsored HRA cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies and therefore will violate PHS Act section 2711.

**Q3: If an employee is offered coverage that satisfies PHS Act section 2711 but does not enroll in that coverage, may an HRA provided to that employee be considered integrated with the coverage and therefore satisfy the requirements of PHS Act section 2711?**

No. The Departments intend to issue guidance under PHS Act section 2711 providing that an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in that coverage. Any HRA that credits additional amounts to an individual when the individual is not enrolled in primary coverage meeting the requirements of PHS Act section 2711 provided by the employer will fail to comply with PHS Act section 2711.

**Q4: How will amounts that are credited or made available under HRAs under terms that were in effect prior to January 1, 2014, be treated?**

The Departments anticipate that future guidance will provide that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014, consisting of amounts credited before January 1, 2013 and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013 may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with PHS Act section 2711. If the HRA terms in effect on January 1, 2013, did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

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<sup>2</sup> With respect to HRAs that are limited to retirees, the exemption from the requirements of ERISA and the Code relating to the Affordable Care Act for plans with fewer than two current employees means that retiree-only HRAs generally are not subject to the rules of PHS Act section 2711. See the preamble to the interim final rules implementing PHS Act section 2711 (75 FR 37188, at 37191). See also ACA Implementation FAQs Part III, issued on October 12, 2010 (available at <http://www.dol.gov/ebsa/faqs/faq-aca3.html>).

## **Disclosure of Information Related to Firearms**

### **Q5: Does PHS Act section 2717(c) restrict communications between health care professionals and their patients concerning firearms or ammunition?**

No. While we have yet to issue guidance on this provision, the statute prohibits an organization operating a wellness or health promotion program from requiring the disclosure of information relating to certain information concerning firearms. However, nothing in this section prohibits or otherwise limits communication between health care professionals and their patients, including communications about firearms. Health care providers can play an important role in promoting gun safety.

## **Self-Insured Employer Prescription Drug Coverage Supplementing Medicare Part D Coverage Provided through Employer Group Waiver Plans**

Medicare Part D is an optional prescription drug benefit provided by prescription drug plans. Employers sometimes provide Medicare Part D coverage through Employer Group Waiver Plans (EGWPs) under title XVIII of the Social Security Act and often supplement the coverage with additional non-Medicare drug benefits. For EGWPs that provide coverage only to retirees, the non-Medicare supplemental drug benefits are exempt from the health coverage requirements of title XXVII of the PHS Act, Part 7 of the Employee Retirement Income Security Act (ERISA), and Chapter 100 of the Code. (For ease of reference, the relevant provisions of the three statutes are referred to here as “the health coverage requirements.”) Moreover, for EGWPs that are insured under a separate policy, certificate, or contract of insurance, the non-Medicare supplemental drug benefits qualify as excepted benefits under PHS Act section 2791(c)(4), ERISA section 733(c)(4), and Code section 9832(c)(4) and are, therefore, similarly exempt from the health coverage requirements.

### **Q6: Must self-insured prescription drug coverage that supplements the standard Medicare Part D coverage through EGWPs comply with the health coverage requirements?**

Pending further guidance, the Departments will not take any enforcement action against a group health plan that is an EGWP because the non-Medicare supplemental drug benefit does not comply with the health coverage requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code. This enforcement policy does not affect other requirements administered by the Centers for Medicare & Medicaid Services that apply to providers of such coverage. The Centers for Medicare & Medicaid Services intends to issue related guidance concerning insured coverage that provides non-Medicare supplemental drug benefits shortly.

## **Fixed Indemnity Insurance**

Fixed indemnity coverage under a group health plan meeting the conditions outlined in the Departments’ regulations<sup>3</sup> is an excepted benefit under PHS Act section 2791(c)(3)(B), ERISA

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<sup>3</sup> See 26 CFR 54.9831-1(c)(4), 29 CFR 732(c)(4), 45 CFR 146.145(c)(4).

section 733(c)(3)(B), and Code section 9832(c)(3)(B). As such, it is exempt from the health coverage requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code. The Departments have noticed a significant increase in the number of health insurance policies labeled as fixed indemnity coverage.

**Q7: What are the circumstances under which fixed indemnity coverage constitutes excepted benefits?**

The Departments' regulations provide that a hospital indemnity or other fixed indemnity insurance policy under a group health plan provides excepted benefits only if:

- The benefits are provided under a separate policy, certificate, or contract of insurance;
- There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and
- The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

The regulations further provide that to be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.

Various situations have come to the attention of the Departments where a health insurance policy is advertised as fixed indemnity coverage, but then covers doctors' visits at \$50 per visit, hospitalization at \$100 per day, various surgical procedures at different dollar rates per procedure, and/or prescription drugs at \$15 per prescription. In such circumstances, for doctors' visits, surgery, and prescription drugs, payment is made not on a per-period basis, but instead is based on the type of procedure or item, such as the surgery or doctor visit actually performed or the prescribed drug, and the amount of payment varies widely based on the type of surgery or the cost of the drug. Because office visits and surgery are not paid based on "a fixed dollar amount per day (or per other period)," a policy such as this is not hospital indemnity or other fixed indemnity insurance, and is therefore not excepted benefits. When a policy pays on a per-service basis as opposed to on a per-period basis, it is in practice a form of health coverage instead of an income replacement policy. Accordingly, it does not meet the conditions for excepted benefits.

The Departments plan to work with the States to ensure that health insurance issuers comply with the relevant requirements for different types of insurance policies and provide consumers with the protections of the Affordable Care Act.

**Payment of PCORI Fees**

Section 4376 of the Code, as added by the Affordable Care Act, imposes a temporary annual fee on the sponsor of an applicable self-insured health plan for plan years ending on or after October 1, 2012, and before October 1, 2019. The fee is equal to the applicable dollar amount in effect for the plan year (\$1 for plan years ending on or after October 1, 2012, and before October 1,

2013) multiplied by the average number of lives covered under the applicable self-insured health plan during the plan year. In the case of (i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations, (ii) a multiple employer welfare arrangement, or (iii) a voluntary employees' beneficiary association (VEBA) described in Code section 501(c)(9), the plan sponsor is defined in Code section 4376(b)(2)(C) as the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

**Q8: Does Title I of ERISA prohibit a multiemployer plan's joint board of trustees from paying the Code section 4376 fee from assets of the plan?**

In the case of a multiemployer plan defined in ERISA section 3(37), the plan sponsor liable for the fee would generally be the independent joint board of trustees appointed by the participating employers and employee organization, and directed pursuant to a collective bargaining agreement to establish the employee benefit plan. Normally, such a joint board of trustees has no function other than to sponsor and administer the multiemployer plan, and it has no source of funding independent of plan assets to satisfy the Code section 4376 statutory obligation. The fee involved is not an excise tax or similar penalty imposed on the trustees in connection with a violation of federal law or a breach of their fiduciary obligations in connection with the plan. Nor would the joint board be acting in a capacity other than as a fiduciary of the plan in paying the fee.<sup>4</sup> In such circumstances, it would be unreasonable to construe the fiduciary provisions of ERISA as prohibiting the use of plan assets to pay such a fee to the Federal government. Thus, unless the plan document specifies a source other than plan assets for payment of the fee under Code section 4376, such a payment from plan assets would be permissible under ERISA.

There may be rare circumstances where sponsors of employee benefit plans that are not multiemployer plans would also be able to use plan assets to pay the Code section 4376 fee, such as a VEBA that provides retiree-only health benefits where the sponsor is a trustee or board of trustees that exists solely for the purpose of sponsoring and administering the plan and that has no source of funding independent of plan assets.

The same conclusion would not necessarily apply, however, to other plan sponsors required to pay the fee under Code section 4376. For example, a group or association of employers that act as a plan sponsor but that also exist for reasons other than solely to sponsor and administer a plan may not use plan assets to pay the fee even if the plan uses a VEBA trust to pay benefits under the plan. The Department of Labor would expect that such an entity or association, like employers that sponsor single employer plans, would have to identify and use some other source of funding to pay the Code section 4376 fee.

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<sup>4</sup> See generally, ERISA Field Assistance Bulletin 2002-02 (trustees of multiemployer plans, if allowed under the plan documents, may act as fiduciaries in carrying out activities that otherwise would be settlor in nature), available at <http://www.dol.gov/ebsa/regs/fab2002-2.html>.