Affordable Care Act FAQs Offer Employers the Good, the Bad, and the Ugly on Notices, EGWPs, Fixed Indemnity, and HRAs

January 2013

The eleventh set of frequently asked questions (FAQs) on administration of the Patient Protection and Affordable Care Act (Affordable Care Act), issued January 24, 2013, offered a range of guidance to employers sponsoring group health plans:

- From the “good”—easing the rules on Exchange notices and employer group waiver plan (EGWP) supplemental benefits;
- To the “bad”—tighter rules on Affordable Care Act exemptions for fixed indemnity benefits; and
- The “ugly”—the application of rules on essential health benefits (EHBs) to health reimbursement arrangements (HRAs).

This Aon Hewitt bulletin discusses the FAQ guidance issued by the Departments of Labor (DOL), Treasury, and Health and Human Services (HHS) (the agencies) on:

- Exchange notices (Note: Exchanges are also referred to as marketplaces as of January 2013);
- HRAs and the rules on dollar limits for EHBs;
- The application of certain Affordable Care Act rules to EGWP supplemental benefits;
- The payment of the Patient-Centered Outcomes Research Institute (PCORI) fee for multiemployer plans; and
- Whether fixed indemnity policies are “excepted benefits” from Affordable Care Act compliance.

Exchanges—For Now, No Notices Needed

The FAQs provide welcome relief to employers wondering when (and how) to issue the Affordable Care Act’s required March 1 notice to employees describing health insurance coverage options available through the Exchanges. The agencies concluded that this notice requirement will not become effective on March 1, 2013, and employers will not be required to issue any notice until regulations are issued and become applicable (likely late summer or early fall of 2013). The DOL is considering providing model generic language or a generic template that could be used to satisfy the notice requirement.

This Will Not Stand—Stand-Alone HRAs and EHBs

Employers received an unwelcome answer to the question of whether stand-alone HRAs covering active employees must comply with the Affordable Care Act’s rule prohibiting health plans and health insurance issuers from imposing lifetime or annual limits on the dollar value of EHBs. The answer? An HRA covering active employees that is not “integrated” with other coverage violates the rule against dollar limits on EHBs.
The FAQs distinguish between a stand-alone HRA covering an active employee and an HRA for an active employee that is integrated with other health insurance coverage as part of a group health plan (e.g., a high-deductible plan). In the latter case, if the other coverage that is integrated with the HRA complies with the prohibition against lifetime and annual dollar limits, the HRA does not violate the rule. However, a stand-alone HRA—which limits the benefits it pays each year—would fail to comply with the prohibition on lifetime and annual dollar limits on EHBs. The FAQs state that an employer-sponsored HRA will be treated as integrated with other coverage only if the employee covered by the HRA is actually enrolled in that coverage. The FAQs also state that an employer-sponsored HRA that is used to subsidize an employee’s purchase of coverage on the individual insurance market, such as through an Exchange, will not be considered integrated with an employer plan.

The agencies noted that HRAs that are limited to retirees, presumably as part of a “stand-alone retiree medical plan,” are not subject to the prohibition on annual and lifetime dollar limits. The FAQs provide a transition rule for HRAs to use existing balances without violating the Affordable Care Act rules on annual or lifetime dollar limits on EHBs. 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 as of January 1, 2013 may be used after December 31, 2013 to reimburse eligible medical expenses without failing to comply with the prohibition against certain dollar limits on EHBs.

Employers will be provided with additional guidance on HRAs in the future.

Reprieve for EGWPs

The FAQs provide limited relief to employers that sponsor supplemental plans to EGWPs and that have been seeking guidance on whether these supplemental plans must comply with the Affordable Care Act’s group insurance reforms. The FAQs state that the agencies will not take any enforcement action against an EGWP whose non-Medicare supplemental drug benefit does not comply with the Affordable Care Act rules on annual or lifetime dollar limits on EHBs. 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 as of January 1, 2013 may be used after December 31, 2013 to reimburse eligible medical expenses without failing to comply with the prohibition against certain dollar limits on EHBs.

The use of supplemental EGWP plans emerged after the Affordable Care Act ended the deductibility of expenses allocated to the Medicare retiree drug subsidy. Many employers offering retiree prescription drug benefits moved to an EGWP, a type of Medicare Part D plan that is sponsored by an employer. Some employers offer a supplemental “wrap” plan to enhance the benefits under the EGWP. Employers have been concerned that the self-insured wrap would be subject to certain Affordable Care Act rules, including: the availability of an external review under new claims and appeals procedures offered to non-grandfathered group health plans; offering in-network preventive care, including medications, with no cost sharing; and no lifetime or annual dollar limits on EHBs. Many employers carved out their retirees into stand-alone retiree medical plans to avoid these requirements. Although the FAQs provide limited relief on this point, additional EGWP guidance is needed.
Payment of PCORI Fees by a Multiemployer Plan

The Affordable Care Act imposes a temporary annual fee (until plan years ending before October 1, 2019) on sponsors of applicable self-insured group health plans to fund the PCORI. According to previous guidance, the PCORI fee cannot be paid from plan assets. The FAQs provide an exception to that rule in the case of a multiemployer plan.

According to the FAQs, in the case of a multiemployer plan, the plan sponsor liable for the fee would generally be the independent joint board of trustees. Normally, the joint board of trustees has no other function than to sponsor and administer the multiemployer plan and has no source of funding independent of plan assets from which to pay the PCORI fee. In these circumstances, the FAQs state that unless the plan document specifies a source other than plan assets for payment of the PCORI fee, a payment made from plan assets would be permissible under ERISA. The FAQs caution that there might 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 fee.

Fixed Indemnity Insurance

The FAQs limit the circumstances under which fixed indemnity plans are exempt from the group market reforms of the Affordable Care Act. The FAQs state that, in order to be an “excepted benefit,” a fixed indemnity policy must meet the following three-part test:

- 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 FAQs state that certain health insurance policies that are being marketed as fixed indemnity coverage actually pay different dollar rates based on the type of procedure or item actually performed or prescribed, such as different rates for surgery, doctor’s visits, and prescription drugs. The FAQs state that when a policy pays on a per-service basis as opposed to a per-period basis, the policy is not an excepted benefit because the policy is, in practice, a form of health coverage instead of an income replacement policy.

Disclosure of Information Related to Firearms

The Affordable Care Act prohibits an organization operating a wellness or health promotion program from requiring the disclosure of certain information related to firearms. The FAQs state that there is no prohibition or limitation regarding communications about firearms between health care professionals and their patients. This follows President Obama’s executive action clarifying that the Affordable Care Act does not prohibit doctors from asking their patients about guns in their homes.

Resources

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