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FAQs Clarify HRAs, Fixed Indemnity Plans, and Other Issues

Recently released Frequently Asked Questions (FAQs) on healthcare reform cover a range of issues about employer responsibilities under the healthcare reform law. The FAQs clarify that employers will violate the prohibition on annual dollar limits on essential health benefits if they offer only stand-alone health reimbursement arrangements (HRAs), such as HRAs used to purchase health coverage in the individual market. Several other frequently asked employer questions are addressed. See our latest Update for more on the FAQ on the postponed March 1 deadline for exchange notices.

Stand-alone HRAs. The FAQs address the types of HRAs that comply with the law's ban on annual and lifetime dollar limits and clarify that HRAs with a specific dollar limit that are not connected to employer coverage ("stand-alone") do not comply with the annual and lifetime limits ban. Generally, group health plans are prohibited from imposing lifetime or annual dollar limits on "essential health benefits" (EHBs). Prior guidance provided that HRAs that are integrated with other coverage as part of a group health plan would satisfy this rule, provided the group health plan coverage does not impose lifetime or annual dollar limits on EHBs. Future guidance will be issued addressing clarifications on these HRA rules, including guidance providing the following:

- HRAs with annual limits must be integrated with other coverage that satisfies the annual and lifetime limits on EHBs. To be integrated with qualifying coverage, HRAs must be limited to employees who actually enroll in the employer group coverage. HRAs that credit additional amounts to individuals when they are not enrolled in other employer-sponsored coverage that complies with the prohibition on lifetime or annual dollar limits on EHBs will fail to comply with that rule.
- Employer-sponsored HRAs cannot be integrated with individual market coverage (such as through an Exchange) or employer coverage provided through individual policies. In such cases, HRAs will violate the prohibition on lifetime or annual dollar limits on EHBs. Because these HRAs are not "integrated" with primary health coverage offered by an employer, they are a type of limited benefit plan prohibited under the healthcare reform law. However, retiree-only plans aren't subject to these provisions, so offering stand-alone HRAs to only retirees remains permissible.
- Existing stand-alone HRAs will comply with the prohibition on lifetime or annual dollar limits on EHBs if, under the HRA terms in effect on January 1, 2013, amounts carried over into or credited in 2013 are used to reimburse medical expenses after December 31, 2013. However, if the HRA terms in effect on January 1, 2013 don't set the amount or timing of 2013 contributions, then the amounts credited may not exceed 2012 levels and may not be

credited at a faster rate than the rate during 2012. For HRA amounts credited after January 1, 2014, to satisfy the annual limit restrictions, the HRA must be integrated with qualifying employer-provided coverage.

Fixed-indemnity plans. Fixed indemnity plans that meet certain conditions are excepted benefits under the healthcare reform law. The regulators have noticed a significant increase in the number of health insurance policies labeled as fixed indemnity coverage. Accordingly, the FAQs address the circumstances under which fixed indemnity coverage constitutes excepted benefits and clarify that hospital indemnity or other fixed indemnity insurance policies under a group health plan provide excepted benefits only if:

- Benefits are provided under a separate policy, certificate, or contract of 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 (policies paying a fixed dollar amount per visit or per service are not an excepted type of fixed-indemnity policy);
- Benefits provided by the policy are not coordinated with any benefits excluded under any group health plan maintained by the same plan sponsor; and
- Benefits for an event are paid without regard to whether any other group health plan offered by the same plan sponsor provides benefits for the same event.

Various situations have come to the attention of the regulators 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.

Medicare Part D - limited nonenforcement policy. 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) and often supplement the coverage with additional non-Medicare drug benefits (essentially, a contract between the employer and a commercial insured Medicare Part D plan). If offered under a retiree-only plan, this supplemental drug coverage does not have to comply with most healthcare reform and other federal 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 and are, therefore, similarly exempt from the health coverage requirements. Pending further guidance, regulators will not take any enforcement action against an EGWP if the supplemental drug benefit violates those standards. This enforcement policy does not affect other requirements administered by the Centers for Medicare & Medicaid Services (CMS) that apply to providers of such coverage. CMS intends to issue related guidance concerning insured coverage that provides non-Medicare supplemental drug benefits shortly. While the FAQs are silent on this issue, the nonenforcement policy does not appear to apply to the Patient-Centered Outcomes Research

Institute (PCORI) fee or the transitional reinsurance fee.

Multiemployer plan PCORI fee. Self-insured health plan sponsors and health insurers must pay Patient-Centered Outcomes Research Institute (PCORI) fees for plan (or policy) years ending on or after October 1, 2012 and before October 1, 2019 (2012 – 2018 for calendar year plans). The amount of the annual fees is $1 multiplied by the average number of covered lives for the plan year ending before October 1, 2013 and $2 multiplied by the average number of covered lives for all later plan years (for calendar year plans, $1 per covered life in 2012 and $2 per covered life for 2013 through 2018). Regarding whether PCORI fees can be paid from plan assets, the FAQs provide that:

- Generally, plan sponsors must use a source of funding other than plan assets to pay PCORI fees.
- For ERISA-covered multiemployer plans, the multiemployer plan's joint board of trustees can pay the PCORI fee from plan assets, unless plan documents specify a different source for payment of this fee.
- In some other (non-multiemployer) circumstances, paying PCORI fees from plan assets would be permissible— 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.
- A group or association of employers that act as plan sponsor but also exist for reasons other than to sponsor and administer a plan may not use plan assets to pay PCORI fees even if the plan uses a VEBA trust to pay plan benefits. It is expected 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 PCORI fee.

Firearms. The FAQs clarify that healthcare professionals may communicate with their patients about firearms, even though the healthcare reform provides that organizations that operate wellness programs may not require disclosure of information regarding the presence or storage of lawfully possessed firearms or ammunition at an individual's home. In addition, premium rates may not be increased, health insurance coverage may not be denied, and wellness program discounts, rebates or rewards under a health plan cannot be reduced or withheld on the basis of firearm ownership, possession, use, or storage.

Should you have questions, contact your Conner Strong & Buckelew account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong & Buckelew, visit our online Resource Center.

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