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ACA FAQs address HRAs, hospital indemnity plans, and PCORI fee

Recently issued FAQs address the treatment of health reimbursement arrangements and fixed indemnity health insurance plans under the Affordable Care Act (ACA). The FAQs generally provide that stand-alone HRAs will not comply with the ACA group health plan mandates prohibiting annual and lifetime limits on the dollar value of essential health benefits. In addition, certain hospital and other fixed indemnity plans that vary payments on a procedural basis and provide payments on a per-service basis as opposed to a per-period basis will not be exempt from ACA requirements. Employers that offer stand-alone HRAs and/or fixed indemnity plans will need to consider the viability of those arrangements in light of these FAQs. The FAQs also address the payment of the Patient-Centered Outcome Research Institute fee by multiemployer plans, finding that under certain circumstances the fee may be paid from plan assets.

Background

Section 2711 of the Public Health Service Act, added by the ACA, generally prohibits plans and issuers from imposing lifetime or annual limits on the dollar value of essential health benefits (EHBs). In the preamble to interim final regulations implementing Section 2711, the agencies addressed the application of this prohibition to health reimbursement arrangements (HRAs) and other account-based arrangements. (See our July 2, 2010 *For Your Information*.) The preamble states that HRAs offered in conjunction (integrated) with group health plan coverage that complies with the rules regarding annual and lifetime dollar limits are not subject to the prohibition. It also provides that the annual and lifetime limit restrictions do not apply to HRAs that cover only retirees. The agencies solicited comments on the treatment of stand-alone HRAs that are not limited to retirees.

ACA requirements generally apply only to group health plans that are subject to the HIPAA portability rules, i.e., those that impose access and renewability requirements on group health plans, including pre-existing conditions limitations and special enrollment rights. Benefits that are generally excepted from HIPAA requirements are also excepted from the ACA's group health plan mandates and insurance market reforms. Reinforcing this concept, interim final regulations specifically provide that retiree-only and HIPAA excepted benefits (such as separate dental and vision plans, health flexible spending arrangements, and hospital indemnity plans) are not subject to the ACA's mandates and insurance reforms, including the prohibition on annual and lifetime dollar limits on EHBs. (See our June 23, 2010 *For Your Information*.) HIPAA excepted benefits include:

- Coverage only for accident or disability income insurance, or any combination
- Coverage issued as a supplement to liability insurance
- Coverage for on-site medical clinics
- Coverage only for a specified disease or illness, hospital indemnity, or other fixed indemnity insurance
- Medicare supplemental health insurance, coverage supplemental to TRICARE, or similar supplemental coverage

HIPAA regulations provide that hospital indemnity and other fixed indemnity coverage will be considered an excepted benefit only if it meets specific regulatory conditions:

- Coverage is provided under a separate policy, certificate, or other fixed indemnity insurance.
- No coordination exists between the provision of such benefits and any exclusion under any plan maintained by the employer.
- Benefits are paid for an event regardless of whether benefits are provided for the same event under any group health plan maintained by the same plan sponsor.

In addition, the regulations provide that in order 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, regardless of the amount of expenses incurred. Finally, the ACA and final regulations provide that a fee to fund the Patient-Centered Outcomes Research Institute (PCORI) is imposed on insurers and plan sponsors of self-insured group health plans. (See our January 23, 2013 *For Your Information*.) For this purpose, an applicable self-insured health plan generally is any plan providing accident and health coverage, other than through insurance, that is established or maintained by employers or employee organizations on behalf of their employees or members. This includes accident and health coverage provided by multiemployer plans and voluntary employee beneficiary associations (VEBAs). In the case of a multiemployer plan or VEBA, the plan sponsor will be the association, committee, joint board of trustees, or similar group that represents the parties that established or maintain the plan.

Recently, the Department of Labor (DOL), Treasury, and Health and Human Services (HHS) released FAQs addressing these issues, among other things: HRAs, fixed indemnity plans, and the PCORI fee for multiemployer plans.

Stand-alone HRAs

HRAs defined

An HRA is an employer-provided medical plan generally subject to ERISA and the Code. The FAQs describe HRAs as group health plans that "typically consist of a promise by an employer to reimburse qualified medical expenses (defined in the Code under section 213(d)) for a year up to a certain amount, with unused amounts

available to reimburse medical expenses in future years." The principles outlined in the FAQs apply to HRAs sponsored by employers, employee organizations, or jointly by employers and employee organizations.

> Buck Comment. The use of the word "typically" in the description of an HRA could indicate the agencies' intent that these principles apply to all HRAs, regardless of whether they allow amounts to roll over to subsequent years. Hopefully, future guidance will clarify the definition of an HRA and how it differs from an account that reimburses premiums described in the proposed cafeteria plan regulations. (See our August 24, 2007, *For Your Information*.)

HRAs not integrated unless employees also enroll in employer's major medical coverage

The FAQs state that an HRA will not be treated as integrated with other major medical coverage that complies with the annual and lifetime dollar limit prohibition unless the employee covered by the HRA is actually enrolled in the other coverage. This means that unless some exception applies, an HRA that credits additional amounts to individuals who are not enrolled in the employer's major medical plan will violate the annual and lifetime limit rules, even if the employer's major medical plan is compliant. Note certain HRAs that limit rollover amounts and are funded with small dollar amounts (e.g., $500) could be considered health flexible spending arrangements under Code section 106(c)(2), and as such, could be an excepted benefit under HIPAA. These HRAs would not violate the annual or lifetime dollar prohibition because, as HIPAA excepted benefits, they are exempt from the requirement.

> Buck comment. Because retiree-only HRAs are not subject to the ACA's prohibition on annual or lifetime dollar limits on EHBs, stand-alone retiree HRAs remain a permissible option for pre- and post-65 retirees. Although it appears that retirees will be able to use HRA funds to purchase coverage through an Exchange, it is not clear whether retirees enrolled in an HRA would be eligible to receive subsidized Exchange coverage. Additional guidance on these issues is needed.

HRAs cannot be integrated with Exchange or individual coverage

The agencies also indicate their intention to issue future guidance providing that employer-sponsored HRAs cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies. Thus, such HRAs will violate the prohibition on annual and lifetime limits.

Existing HRAs

The FAQs provide a grandfather-type rule for amounts credited to HRAs before January 1, 2014. Amounts credited to an HRA prior to January 1, 2014, may be used after December 31, 2013, to reimburse medical expenses in accordance with the plan's terms as in effect on January 1, 2013, without violating the limit rules. This rule applies regardless of whether the HRA is integrated with other coverage or stand-alone. However, if the HRA terms in effect on January 1, 2013, did not prescribe (1) a set amount to be credited during 2013, or (2) the timing for crediting such amounts, then the amounts credited in 2013 may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

Fixed indemnity insurance

Treatment of fixed indemnity plan as HIPAA excepted benefit

As described in the Background section, hospital indemnity or other fixed indemnity coverage is considered a HIPAA excepted benefit, exempt from ACA market mandates and insurance reforms, as well as HIPAA portability and nondiscrimination rules. In the FAQs, the agencies note that they have seen an increase in the number of health insurance policies characterized as "fixed indemnity coverage" that base the amount of payment on the type of procedure or item (e.g., doctors' visits covered at $50 per visit, hospitalization at $100 per day, surgical procedures covered at different dollar rates per procedure, and/or prescription drugs covered at $15 per prescription).

The FAQs provide that under a HIPAA-exempt indemnity plan, the payment for doctors' visits, surgery, and prescription drugs is made on a per-period basis, based on a fixed dollar amount per day (or per other period). They state that when a policy pays on a per-service basis as opposed to a per-period basis, "it is in practice a form of health coverage instead of an income replacement policy." The agencies observe that policies paying on a per-service basis are not hospital indemnity or other fixed indemnity coverage, and are therefore not excepted benefits.

> Buck comment. If employer-sponsored hospital or other fixed indemnity coverage is not considered a HIPAA excepted benefit, then it would be subject to HIPAA and other legal requirements, including the ACA mandates and insurance reforms, such as the prohibition of annual and lifetime dollar limits on EHBs.

Enforcement

The FAQs say that the agencies will work with the states to ensure that insurance issuers comply with relevant requirements and provide consumers with the protections of the ACA.

Multiemployer plan payment of PCORI fee

The plan sponsor liable for a multiemployer plan's PCORI fee is generally an independent joint board of trustees with no source of funding other than plan assets. Previously, it was not clear whether plan assets could be used to pay the fee. The FAQs state that, where the joint board of trustees exists solely for the purpose of sponsoring and administering a plan and has no source of funding independent of plan assets, payment of the PCORI fee from plan assets would be permissible under ERISA. They note that this principle would also apply to other situations, such as in the case of a VEBA providing retiree-only coverage, but only if the VEBA trustee or board of trustees does not exist for any reason other than to sponsor or administer the plan.

In closing

These FAQs are not formal guidance, but they provide the agencies' positions on a variety of important topics. Employers that currently sponsor HRAs or contemplate establishing HRAs should consider these FAQs when making decisions about plan design. Employers could consider limiting HRA coverage eligibility to employees enrolled in the employer group health plans. Employers implementing or offering fixed indemnity coverage should confirm that the coverage complies with applicable legal requirements.

Authors
Sharon Cohen, JD
Leslye Laderman, JD, LLM

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