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FYI® Roundup
For Your Information®

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Health and Welfare Benefits 2014 – Summer Edition

Our latest *FYI Roundup* highlights some of the recent developments affecting health and welfare benefits.

Affordable Care Act Developments

The Affordable Care Act (ACA) was in the forefront during the second quarter of 2014 with a Supreme Court ruling and additional guidance issued on several aspects of the ACA.

High Court Strikes Contraceptive Coverage Mandate for Closely Held, For-Profit Employers with Religious Objections

The ACA requires non-grandfathered group health plans to provide in-network, FDA-approved contraceptive services without cost-sharing. Churches and conventions or associations of churches are exempt from the contraceptive coverage mandate while other nonprofit religious entities meeting certain requirements have been provided an accommodation for satisfying it. For-profit secular organizations, however, are not eligible for an exemption or an accommodation. (See our October 18, 2013 *For Your Information*.)

On June 30, the Supreme Court ruled that the Religious Freedom Restoration Act gives closely-held for-profit employers the right to refuse to provide coverage of specific contraceptive methods that conflict with the company owners' sincerely held religious beliefs. The Court held that the contraceptive coverage mandate "substantially burdens" the corporations' exercise of religion because it requires them either to violate their religious beliefs or incur an ACA penalty for failing to comply with the mandate. (See our June 30, 2014 *FYI Alert*.)

Departments Issue Final Regulations Addressing ACA's 90-Day Waiting Period Limitation

For plan years beginning on or after January 1, 2014, group health plans subject to the ACA may not impose a waiting period of more than 90 days on individuals who are otherwise eligible for coverage. Final regulations issued by the Departments of Treasury, Labor, and Health & Human Services (departments) on the 90-day waiting period limit retain the definition of waiting period set out in the proposed regulations and also clarify that being "otherwise eligible to enroll in a plan" means that the individual has met the plan's substantive eligibility conditions, including satisfaction of any "reasonable and bona fide" orientation period. (See our April 2, 2014 *For Your Information*.)

In June, the departments also issued final regulations that set out rules regarding this orientation period. The regulations permit an orientation period of no longer than one month, which is measured by adding one calendar month and subtracting one calendar day from an employee's start date. (See our July 3, 2014 *For Your Information*.)

DOL Updates Model COBRA Notices to Highlight Marketplace Options

With the availability of the ACA marketplace, individuals who lose employment-related coverage due to a COBRA qualifying event now may choose COBRA coverage or enroll in marketplace coverage. The DOL recently issued a new model COBRA election notice that advises qualified beneficiaries about the availability and advantages of marketplace coverage, and points out some factors they should consider in choosing a coverage option. It also issued a new model general COBRA notice that refers to the availability of marketplace coverage. (See our June 3, 2014 *For Your Information*.)

FAQs Offer Guidance on Out-Of-Pocket Maximums, Preventive Care, SBCs, and More

The departments recently issued FAQs that, among other things, discuss how the ACA limit on the amount that an enrollee in a non-grandfathered plan must pay, through cost-sharing, for essential health benefits may be applied. In addition to describing how a plan with different tiers of prescription drugs may be designed to provide that only generic drugs (and not brand drugs) would be essential health benefits subject to the out-of-pocket maximum, the FAQs also explain how a plan may apply the out-of-pocket maximum in the case of reference-based pricing or when a participant is balance-billed after using an out-of-network provider. They also address how non-grandfathered plans may satisfy the requirement that they cover tobacco cessation interventions without any cost-sharing as part of the preventive services mandate.

In addition to these topics, the FAQs confirm that, until further guidance is issued, the current SBC template continues to be authorized for use and that the departments will focus on assisting with compliance rather than imposing penalties. They also clarify that health FSA carryovers will not be taken into account when determining if a health FSA satisfies the maximum benefit payable limit for purposes of determining an FSA's status as an excepted benefit. (See our June 10, 2014 *For Your Information*.)

Final Regulations Address Opt-Out for Non-Federal Governmental Group Health Plans

The Department of Health & Human Services issued final regulations that modify the "HIPAA opt-out" process for self-funded, non-federal governmental group health plans. Although changes by the ACA now preclude these plans from opting out of the HIPAA portability provisions, they may still opt out from complying with the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, Michelle's Law, and/or the Mental Health Parity and Addiction Equity Act. The final rules reflect the ACA changes to the opt-out provisions, explain the terms and conditions necessary to make an opt-out election, and require that opt-out elections made after December 31, 2014 be submitted electronically. They also clarify that a sponsor of multiple group health plans that are not subject to collective bargaining must file a separate election for each group health plan for which an opt-out is desired. In contrast, a sponsor of multiple group health plans subject to the same collective bargaining agreement may file one opt-out election, but must list each group health plan subject to the agreement in the opt-out election documentation. (See our June 16, 2014 *For Your Information*.)

PCORI Fee Due by July 31

The ACA imposes a fee on health insurance issuers and plan sponsors of self-insured group health plans to help fund the Patient Centered Outcomes Research Institute (PCORI). PCORI is responsible for conducting research to

evaluate and compare the health outcomes and clinical effectiveness, risks, and benefits of medical treatments, services, procedures, and drugs. The PCORI fee, which is assessed for plan years ending after September 30, 2012 and before September 30, 2019, is due by July 31 of the calendar year immediately following the last day of that plan year. The fee is $1 times the average number of covered lives or $2 per covered life, depending on when the plan year ended. (See our January 23, 2013 *For Your Information*.) The IRS has released the 2014 Form 720 that health insurance issuers and plan sponsors of self-insured group health plans will use to report and pay the PCORI fee. (See our June 17, 2014 *For Your Information*.)

Marketplace Premium Payment Plans May be Unhealthy for Employers

Historically, employers have been able to reimburse, on a tax-free basis, employees' properly substantiated premiums for individual medical coverage. The IRS has recently stated, however, that an arrangement in which an employer reimburses an employee for individual medical coverage premiums (purchased either inside or outside the marketplace) on a pre-tax basis is a group health plan that is subject to, but will not comply with, the ACA market reforms. The IRS also noted that because these arrangements are not compliant, employers sponsoring them may be subject to significant excise taxes. (See our July 8, 2014 *For Your Information*.)

Guidance Affecting Health FSAs

This spring, the IRS provided guidance relating to the health FSA carryover option and methods for correcting improper payments from health FSAs.

IRS Addresses Health FSA Carryover and HSA Eligibility Issues

The IRS Office of Chief Counsel issued a memorandum that provides guidance on how employers may provide for carryovers of unused funds from a general purpose health FSA without adversely affecting employees' HSA eligibility. The carryover of up to $500 in unused health FSA amounts for use in the immediately following plan year was authorized by the IRS last fall. (See our November 1, 2013 *For Your Information*.) The memorandum also discusses how the "uniform coverage rule" for health FSAs is applied when amounts are carried over from a general purpose health FSA to an HSA-compatible health FSA. (See our April 24, 2014 *For Your Information*.)

IRS Clarifies Rules for Correcting Improper Payments from Health FSAs

The IRS Office of Chief Counsel issued a memorandum that provides guidance on the procedures an employer may use to correct health FSA payments made for ineligible expenses or expenses that are not properly substantiated. The memorandum also addresses how an employer should report improper payments that have not been corrected after other correction procedures have been exhausted. (See our May 6, 2014 *For Your Information*.)

2015 HSA/HDHP Limits Announced

The IRS has released the 2015 limits for HSAs and HDHPs. The deductible, out-of-pocket, and contribution amounts have all increased over 2014. Plan sponsors will want to review the impact of the limits on current and proposed HSA/HDHP arrangements and update their enrollment materials in anticipation of the new limits. (See our April 29, 2014 *For Your Information*.)

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CMS Releases 2015 Medicare Part D Benefit Parameters and Provides Guidance on Budget Sequestration Reductions

CMS has released the 2015 Medicare Part D standard benefit parameters and the cost thresholds and limits for qualified retiree prescription drug plans. The standard benefit parameters will increase from 2014 by approximately 3 to 4%. Plan sponsors that intend to remain qualified for the employer retiree drug subsidy will have to determine if their 2015 prescription drug coverage is at least actuarially equivalent to the standard Medicare Part D coverage. Guidance was also released on the reduction in retiree drug subsidy payments that was effective in 2013 due to the budget sequestration, enacted as part of the Budget Control Act of 2011. (See our April 30, 2014 *For Your Information*.)

Supreme Court to Decide Whether Retiree Health Benefits Last a Lifetime

The Supreme Court agreed to review a case that could have significant financial implications for employers facing so-called “legacy” lifetime retiree health benefits. In M&G Polymers USA, LLC v. Tackett, the Court is poised to resolve an appellate court split about the interpretation of collective bargaining agreements that provide for retiree health benefits but are silent on the duration of those benefits. With medical costs rising and a growing number of baby boomers leaving the workforce, many employers have sought to manage costs by eliminating or limiting retiree health coverage. This decision could have significant financial implications for employers struggling to contain retiree health care costs. The Court will hear the case during its October 2014 term, with a decision expected by June 2015. (See our May 23, 2014 *For Your Information*.)

San Francisco Bay Area Employers Required to Provide Commuter Benefits

The Metropolitan Transportation Commission and the Bay Area Air Quality Management District jointly launched the Bay Area Commuter Benefits Program to reduce greenhouse gas emissions and traffic congestion by encouraging employees to commute by means other than driving alone. The pilot program extends through December 2016 and requires employers with 50 or more full-time employees in the San Francisco Bay area to offer commuter benefits to their employees by September 30, 2014. (See our May 13, 2014 *For Your Information*.)

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