LABOR & EMPLOYEE BENEFITS LAW

HOLM & O'HARA LLP

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TIME FOR ACA COMPLIANCE REVIEW AS 2014 ARRIVES

With Jan. 1, 2014 here next month, Trustees of governmental health plans should review their plans to ensure that they have made all required amendments to comply with the Affordable Care Act, as the bulk of the law will be in place and Trustees should be prepared for audit and enforcement efforts by governmental agencies.

As this newsletter has previously discussed, by now governmental health plans (both fully and self-insured) should have amended their plans for the following requirements under the ACA:

- Any dependent coverage to age 26;
- No lifetime dollar limits on "essential health benefits" as defined by the ACA and regulations;
- No annual dollar limits on essential health benefits below $2 million for plan years starting on or after Sept. 23, 2012 but before Jan. 1, 2014, unless the plan received a waiver through a program established by the U.S. Department of Health and Human Services (HHS); and
- No pre-existing condition exclusions or limitations on children under age 19.

A few additional ACA requirements that are related to those listed above take effect for plan years beginning on or after Jan. 1, 2014. For example:

- Plans that received a waiver from HHS temporarily permitting annual dollar limits on essential health benefits must eliminate any such dollar limits effective for plan years beginning on or after Jan. 1, 2014.
- An exception to the requirement to provide any dependent coverage to age 26 based on the availability of other employer-provided coverage will no longer be available.
- No pre-existing condition exclusions or limitations are permitted for children or adults.

Trustees should work with their professionals to ensure that plans have been amended to comply with these ACA requirements, as applicable. As this newsletter has previously discussed, removing annual and lifetime dollar limits on essential health benefits, which include prescription drugs and pediatric oral and vision care among other benefits, have costs which require Trustees to review the potential financial impact to their plans. Plans should consider whether benefits are fully or self-insured, potential loss of grandfathered status from a cut in benefits, and the plan's size and financial condition.

PLAN SPONSORS OF HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS) MUST REVIEW NEW ACA RULES

Due to looming mandates under the Affordable Care Act effective Jan. 1, 2014, governmental health plans that provide cash reimbursements to participants on a pre-tax basis through Health Reimbursement Arrangements ("HRAs") must be aware of restrictions that apply specifically to these types of arrangements. The U.S. Department of Labor ("DOL") and IRS recently issued guidance describing which types of HRAs will and will not be permitted under the change in law. Trustees of plans that currently or plan to provide HRAs should review the recent guidance with their professionals and determine whether their HRAs are ACA-compliant.

An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined in Section 213(d) of the Internal Revenue Code) incurred by the employee, or his spouse, dependents, and any children who, as of the end of the tax year, have not attained age 27, up to a maximum dollar amount for a coverage period. This reimbursement is excludable from the employee's income, and amounts that remain at the end of the year generally (cont. next page)

IRS CYCLE C FILINGS FOR RETIREMENT PLANS

- Governmental retirement plans opting to submit IRS determination letter requests in Cycle "C," the designated 1-year filing cycle for individually designed governmental plans, must submit their applications to the IRS by Jan. 31, 2014. Plan Trustees should work with their professionals to ensure that their plans have adopted all required amendments for governmental plans, as provided in the IRS's 2012 Cumulative List, Notice 2012-76.
- Rather than filing in the Cycle "C" ending Jan. 31, 2014, individually designed governmental plans may choose to file in the second Cycle "E," the 1-year period from Feb. 1, 2015 through Jan. 31, 2016, the IRS announced in Rev. Proc. 2012-50.

NEW RULES FOR HRAS UNDER THE ACA

can be used to reimburse expenses incurred in later years.

As plan sponsors are aware, effective for plan years beginning on or after Jan. 1, 2014, group health plans may not impose annual dollar limits on "essential health benefits" within the meaning of the ACA. The preamble to the 2010 interim final regulations implementing the annual dollar limit rule specified that HRAs are subject to the annual dollar limit prohibition. The preamble further stated that if an HRA is "integrated" with other coverage as part of a group health plan, and the other coverage alone would comply with the annual dollar limit prohibition, the fact that benefits under the HRA by itself are limited does not fail to comply with the annual dollar limit prohibition, because the combined benefit satisfies the requirements.

In DOL Technical Release 2013-03 and IRS Notice 2013-54, the DOL and IRS announced that an HRA will be considered "integrated" with a group health plan for purposes of the annual dollar limit prohibition and the ACA's preventive services requirements if it meets the requirements under either of two (2) "integration methods" specified in the guidance. Importantly, the DOL and IRS also clarified that under both methods, integration does not require that the HRA and the coverage with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. Therefore, collectively bargained supplemental health plans, such as those providing limited benefits including prescription drugs, dental, optical and other benefits, may be able to reimburse participants for expenses incurred through their major medical plans if the plans follow the rules set forth in the guidance.

The two "integration methods" that plans can follow to ensure that their HRA is compliant with the ACA are based on whether the group health plan with which the HRA is integrated provides "minimum value" under the Internal Revenue Code.

Founded over twenty-five years ago, Holm & O'Hara LLP is a general practice law firm in New York City with specialties in employee benefits, labor law, litigation, real estate, trust and estates and commercial transactions. The firm is currently composed of five partners, five associates and six paralegals. Holm & O'Hara LLP represents and counsels unions, employee benefit plans, public and privately held corporations, individuals and associations.

The labor law practice provides representation primarily to unions in the construction, hotel, utility and railroad industries, as well as the public sector. The employee benefits practice provides counseling and litigation services to Taft-Hartley multiemployer plans, as well as governmental plans, as defined under the Employee Retirement Income Security Act of 1974 ("ERISA"). The firm's employee benefits counseling is led by founding partner Vincent F. O'Hara and associate Timothy S. Klimpl. The firm also provides unions with benefits advice for negotiations and arbitrations in the areas of pension and health benefits. Holm & O'Hara LLP is proud of the quality of its representation. We provide both legal and strategic advice for the benefit of our clients.

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HEALTH PLANS MUST TRACK PCORI & REINSURANCE FEES

Trustees of self-insured health plans will potentially need to monitor payment of two (2) annual fees under the ACA over the next several years: 1) the Patient-Centered Outcomes Research Institute (PCORI) fee; and 2) a transitional reinsurance fee.

PCORI Fee

The PCORI fee, which applies broadly to most insurance policies and self-insured plans (generally including governmental plans), is a fee that helps fund the Patient-Centered Outcomes Research Institute established by the ACA.

The PCORI fee applies to specified health insurance policies with policy years ending after Sept. 30, 2012, and before Oct.1, 2019, and applicable self-insured health plans with plan years ending after Sept. 30, 2012, and before Oct. 1, 2019. The PCORI fee is due on July 31 of the year following the last day of the policy or plan year. Therefore, the first plan payments of the PCORI fee began in 2013 when calendar-year plans were required to make their payment for plan years ending December 31, 2012 by July 31, 2013. The amount of the PCORI fee is equal to the average number of lives covered during the policy year or plan year multiplied by the applicable dollar amount for the year. The applicable dollar amount for self-insured health plans for the plan year ending after Sept. 30, 2012, but before Oct. 1, 2013, was $1.00. For plan years ending after Sept. 30, 2013, and before Oct.1, 2014, the applicable dollar amount is $2.00.

Transitional Reinsurance Fee

The transitional reinsurance fee is an annual fee for fully-insured and self-insured group health plans from 2014-2016 to stabilize insurance premiums in the individual market. For 2014, the fee is $63 ($5.25 per month) per covered life. Plans are required to report an annual enrollment count for the fee to HHS by Nov. 15 of each year (2014, 2015 and 2016) that the fee applies.

In a final rule published Mar. 11, 2013, HHS confirmed that the fee does not apply to coverage that is not "major medical coverage" under the rule.