LABOR & EMPLOYEE BENEFITS LAW

HOLM & O'HARA LLP

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HEALTH PLANS MUST PAY ACA REINSURANCE FEES FOR 2014, REVIEW EXEMPTION FOR 2015 AND 2016

Most health insurance issuers, and third-party administrators on behalf of self-insured group health plans, are required to report and pay a fee under a "transitional reinsurance program" established by Section 1341 of the 2010 Patient Protection and Affordable Care Act ("ACA"). The transitional reinsurance program fee ("Fee") was created to support payments to individual market issuers that cover high-cost individuals. The Fee applies to any "contributing entity" as defined in the law and the final rule, which for 2014 includes most self-insured group health plans that provide major medical coverage.

Under the March 2014 final rule implementing the Fee, plans covered by the Fee are required to submit an enrollment count to the U.S. Department of Health and Human Services ("HHS"), through the website Pay.gov.

The due date for contributing entities to submit their enrollment counts to HHS is Nov. 15 of each year to which the Fee applies. However, HHS announced an extension of the due date to submit the enrollment count for the 2014 Fee to 11:59 pm on December 5, 2014.

Under the final rule and according to HHS, a reinsurance contribution payment of $52.50 per covered life (based on the enrollment count submitted by contributing entities) will be invoiced by HHS to contributing entities in December 2014, and payable by Jan. 15, 2015. Another reinsurance contribution payment of $10.50 per covered life will be invoiced in the fourth quarter of 2015, and payable by Nov. 15, 2015. Based on guidance from the Centers for Medicare and Medicaid Services ("CMS"), plans may alternatively pay the entire $63 per covered life for 2014 by Jan. 15, 2015. For 2015, the Fee is $44 per covered life. These timeframes for submitting a plan's annual enrollment count and paying the Fee apply to a covered plan regardless of its fiscal year, as the Fee applies to the 2014, 2015 and 2016 calendar years (what the regulation calls "benefit years").

As discussed above, the Fee applies to plans that provide major medical coverage. In the final rule, HHS defined "major medical coverage" to include, in part, "health coverage for a broad range of services and treatments provided in various settings," that meet the minimum value standards of the ACA. Therefore, plans should first determine that their coverage provided is "major medical coverage" that is covered by the Fee.

Importantly, for the 2015 and 2016 benefit years, HHS has excluded certain (over)

IRS CYCLE E BEGINS FOR RETIREMENT PLANS

- Individually designed governmental retirement plans that did not submit IRS determination letter requests in Cycle "C" that ended Jan. 31, 2014, may begin submitting applications to the IRS on Feb. 1, 2015, under Cycle "E." Applications under Cycle E may be submitted through Jan. 31, 2016. 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 2014 Cumulative List published at the end of this year.
- Trustees should ensure that by Dec. 31, 2014, their plans' definition of "spouse" and similar terms do not conflict with the 2013 U.S. v. Windsor decision, which invalidated the Defense of Marriage Act ("DOMA").

IRS LIST IS KEY FOR RETIREMENT PLANS' TAX STATUS

Retirement plans that enjoy tax-qualified status under Section 401(a) of the Internal Revenue Code ("Code"), including many governmental pension and annuity plans, are subject to numerous requirements as conditions to keeping their tax-qualified status. And while not legally required, in order to avoid stiffer penalties on audit (including costly sanctions and loss of tax-qualified status), many plans participate in the IRS's Determination Letter Program. Depending on the plan type (i.e., individually designed or pre-approved), plans have a five (5) or six (6)-year period for which a Determination Letter will cover a plan document. An individually designed plan's Determination Letter has an expiration date. During a plan's one-year "on-cycle" period, the plan may request a new letter from the IRS for the next five or six years, as applicable.

When the IRS reviews a plan for qualified status, it bases its review of the plan on the "Cumulative List" that it has published for the applicable one-year submission period. The list includes many specific items under the Code and is published at the end of each year, usually in December, before the next filing period starts.

TRANSITIONAL REINSURANCE FEES

self-insured, self-administered plans from being subject to the Fee. The final rule provides that for the 2015 and 2016 benefit years, a contributing entity includes a self-insured group health plan (including a group health plan that is partially self-insured and partially insured, where the insured coverage does not constitute major medical coverage) that uses a third party administrator in connection with claims processing or adjudication (including the management of internal appeals) or plan enrollment for services other than for pharmacy benefits or "excepted benefits" under the Public Health Services Act. A self-insured group health plan will not be considered to use a "third party administrator" if the plan uses an unrelated third party to obtain provider network and related claim repricing services, or if the plan uses an unrelated third party for up to 5% of claims processing or adjudication or plan enrollment, based on either the number of transactions processed by the third party, or the volume of the claims processing and adjudication and plan enrollment services provided by the third party.

Based on the above, self-insured plans that do not use a third party administrator ("TPA") for the core administrative functions described in the rule are exempt from reporting and paying the Fee for the 2015 and 2016 benefit years. Therefore, many self-insured plans that are administered "in house" (without a TPA) may be responsible for reporting and paying the Fee for 2014, but not for 2015 or 2016.

Particularly in light of the amount of the Fee ($63 per covered life for 2014 and $44 per covered life for 2015), health plans should carefully review their funding (self-insured, fully insured or a combination) and administration (TPA or "in house") statuses to determine their reinsurance payment obligations for 2014, and possible exemptions for 2015 and 2016.

Plans should also note that the Fee does not apply to individuals with other coverage as their primary, such as Medicare.

Founded over twenty-five years ago, Holm & O'Hara LLP is a general practice law firm in New York City concentrating in employee benefits, labor law, litigation, real estate, trusts and estates and commercial transactions. The firm is comprised of five partners, six associates and seven 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, 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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UPDATED COBRA MODEL NOTICES ISSUED BY LABOR DEPARTMENT

The U.S. Department of Labor ("DOL") has proposed new rules for group health plans when they notify plan participants and beneficiaries about their rights to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). As part of the proposed rules, the DOL released updated model notices to help plans satisfy their COBRA obligations. Plans are not required to use these model notices, but they may wish to begin using them as the DOL (and likely by extension, the other agencies that enforce COBRA for governmental plans) will consider use of the model notices as good faith compliance with the new COBRA notice rules when they are finalized.

The DOL released two updated model notices: (1) the General Notice, which is given when participants join the plan (usually in a plan's Summary Plan Description), and (2) the Election Notice, which is provided to participants, spouses and dependents when they lose coverage due to a COBRA "qualifying event" (e.g., termination of employment, reduction in hours worked, divorce or legal separation, or loss of dependent status under the plan, among others). The updated notices include information about the Health Insurance Marketplaces, also known as the "Exchanges" created by the Patient Protection and Affordable Care Act.

Plans should note that the DOL has issued its model notices for use by single-employer plans, but multiemployer plans may also use the notices as templates because the COBRA requirements are largely the same for all group health plans. As with the prior COBRA model notices, the notices need to be completed by plans in the appropriate places on the notices, such as contact information for the plan administrator and the amount of the monthly premium for COBRA coverage. Additionally, for multiemployer plans that provide retiree health coverage, an optional box on the model General Notice regarding a loss of retiree coverage due to an employer's bankruptcy may not apply.

The updated DOL COBRA model notices can be found at the following page on the DOL website, under "For Employers": http://www.dol.gov/ebsa/cobra.html.