Departments Release 11th Set of FAQs under the Affordable Care Act

On January 24, the Departments of Labor, Health and Human Services, and the Treasury (the Departments) released the eleventh in a series of frequently asked questions and answers (FAQs) regarding the implementation of the Affordable Care Act (the Act).

Most notably, the FAQs announce a delay in the first date by which employers must distribute certain information about health insurance exchanges to current and new employees from March 1, 2013 to an unspecified date in the late summer or fall of 2013 that will coordinate with the open enrollment period for the exchanges. In addition, the FAQs provide additional guidance on the compliance of health reimbursement arrangements (HRAs) with the Act's general prohibition on plans and issuers imposing lifetime or annual limits on the dollar value of essential health benefits.

Delay of Exchange Notice Requirement

The Affordable Care Act generally requires that all employers subject to the Fair Labor Standards Act provide each employee at the time of hiring (or, in the case of a current employee, no later than March 1, 2013) with a written notice containing specific information relating to the employee's health insurance coverage options offered through health insurance exchanges.

In the FAQs, the Department of Labor (DOL) has announced that the notice requirement will not take effect on March 1, 2013 and that the timing for distribution of notices will be the late summer or fall of 2013, in order to best coordinate with the open enrollment period for the exchanges. The FAQs indicate that future guidance is expected to provide flexibility and an applicability date that provides employers with adequate time to comply, while ensuring that employees receive the notice "at a meaningful time."

The FAQs also indicate that the DOL is considering providing model language that could be used to satisfy the notice requirement and permitting employers to comply with the notice requirement by providing employees with certain information using an employer coverage template that will be available for download at the exchange website.

Health Reimbursement Arrangements

In general, the Act prohibits plans and issuers from imposing lifetime or annual limits on the dollar value of essential health benefits. This prohibition has thrown into question the ongoing viability of HRAs (except those limited to retirees), which typically consist of a promise by an employer to reimburse medical expenses for a year up to a certain dollar amount (with unused amounts possibly available to carry over to future years). The preamble to the Departments' interim final regulations implementing this provision addresses its application to non-retiree only HRAs and, in doing so, differentiates HRAs that are "integrated" with group health plan coverage that complies with the prohibition on lifetime and annual limits from HRAs that are considered to provide "stand-alone" coverage. According to the preamble, in the former case, the fact that benefits under the HRA itself are limited does not violate the prohibition on lifetime and annual limits because the combined benefit satisfies the Act's requirements.

The FAQ provides additional guidance on the ability to "integrate" HRAs with other coverage that satisfies the prohibition on lifetime and annual limits. Specifically, the FAQs explain that an HRA cannot be integrated with coverage purchased on the individual market, meaning that an HRA used to purchase such coverage would be a "stand-alone" HRA that violates the prohibition on lifetime and annual limits. The

Departments intend to issue guidance both on this point and a number of other issues concerning HRAs, including clarifying that an employer-sponsored HRA may be treated as integrated with other group health plan coverage only if the employee receiving the HRA is actually enrolled in that coverage.

The FAQs also anticipate a grandfathering rule for all HRAs, including those that would otherwise violate the prohibition on lifetime and annual limits, under which amounts credited before January 1, 2013 and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013 may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the prohibition on lifetime and annual limits.

Other Issues Addressed

The FAQs also address the disclosure of information related to firearms under the PHS Act, the application of the Act to self-insured employer prescription drug coverage that supplements Medicare Part D coverage through Employer Group Waiver Plans, the ability of a multiemployer plan (or, in certain rare instances, the sponsor of a VEBA) to use ERISA plan assets to pay Patient Centered Outcomes Research Trust Fund Fees, and the circumstances under which fixed indemnity insurance constitutes an excepted benefit under certain provisions of the PHS Act, ERISA and the Internal Revenue Code.

For more information about the topics addressed in this set of FAQs, please contact your usual Ropes & Gray advisor or a member of the employee benefits practice group. For information on federal health reform generally, please visit our Health Reform Resource Center.