IAA Legislative Ledger

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2013 ACA Wrap-Up

This IAA Update includes some "Happy New Year" Healthcare Reform items

New Proposed Rule on "Excepted Benefits"

The Departments of Treasury, Labor and HHS released a proposed rule on "excepted benefits" that permits self-funded dental and vision benefits to qualify as "excepted benefits" effective immediately, even if they do not require contributions from employees. Insured vision and dental benefits, as well as self-funded vision and dental coverage that require employee contributions, already qualify as "excepted benefits."

Also, effective immediately, the proposed rules would amend current regulations to treat certain EAPs as "excepted benefits." I'll let you know what "certain" EAPs mean as the information becomes available.

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"Excepted benefits" are not subject to the major group market reform provisions in the ACA (e.g., prohibition on lifetime and annual limits, pre-existing condition prohibitions).

Can Employees Sue an Employer for a 32-Hour Eligibility Requirement?

The IRS will not impose penalties on employers for failing to offer coverage to employees who work at least 30 hours a week and receive subsidies in 2014 through the Exchanges (IRS Notice 2013-45).

Some employers are asking IAA if an employee can sue an employer for coverage if they work 30 hours a week. There is no employee right of action under section 4980H. Section 4980H does not require an employer to provide coverage. 4980H imposes excise taxes on employers who do not offer certain coverage to full-time employees when there is a full-time employee who receives a subsidy in the Exchange. An employer is out of compliance with 4980H only when the <u>employer</u> does not pay the taxes that are owed to the IRS. If an employer wishes to pay the excise taxes, and they pay the correct amount, they are in compliance with the law. *(Please reread first sentence in this paragraph)*

Defined Contribution Plans for Individual Market Coverage Not Allowed

IRS released guidance (IRS Notice 2013-54) closing the door on an option some employers may consider in 2014 or when the employer shared responsibility (Pay or Play) penalties go into effect in 2015. Some employers may think it would be easier to drop their major medical plan and set up a defined contribution arrangement, offering employer-funded, tax free payment of individual policies purchased inside or outside the Exchange (or pre-tax salary reductions through a cafeteria plan). These employers may

think this is a way to free themselves from the responsibilities of sponsoring a major medical plan. IRS Notice 2013-54 imposes strong penalties for taking this approach - $100 per day per beneficiary under Section 4980D. This IRS Notice, while a technically challenging piece to decipher, is also a policy statement indicating the agencies' goal of preventing employers from moving toward defined contribution approaches paired with individual policies.

Does an employer need to include COBRA participants on the W-2 Health Coverage Reporting?

If a W-2 is issued to an individual, then the cost of employer-provided health care coverage must be included, as required under §6051(a)(14) of the Internal Revenue Code, enacted as part of the Patient Protection and Affordable Care Act. *This reporting requirement does not apply to employers that file fewer than 250 W-2 Forms for the preceding calendar year.* If the employer does not issue a W-2 to an individual, then no W-2 must be issued just for purposes of reporting health care costs.

When an employee terminates mid-year and elects COBRA, the guidance gives employers the option to apply "any reasonable method" for reporting the cost of coverage on the W-2 Form, provided that the method selected is consistent for all employees who continue to receive coverage after termination of employment. Q&A 6 of IRS Notice 2012-9 gives two examples of a reasonable method. In one example, the employer reports only the cost of coverage during the months when the employee had coverage as an active employee. In another example, the employer reports the cost of coverage during the periods in which the employee had coverage by virtue of active status as well as the periods when the employee had continuation coverage.

Mental Health Parity and Addiction Equity Act Final Regulations Issued

The Departments of Labor, Treasury and Health and Human Services (the Departments) issued final regulations in November, which will take effect for plan years commencing on or after January 1, 2014. The changes impose standards for mental health or substance use disorder benefits that will impact most group health plans and health insurance issuers in the group market as a result of the Affordable Care Act (ACA) qualified health plans, Medicaid non-managed care benchmark and benchmark-equivalent plans and plans offered in the individual insurance market.

Where it is possible for a plan to impose aggregate annual or lifetime dollar limits on mental health or substance use disorder benefits, the final regulations clarify that the regulations issued under MHPA will apply. Generally, a group plan providing both medical/surgical benefits and mental health benefits may comply with MHPAEA parity requirements by:

- Not including any aggregate lifetime dollar limit or annual dollar limit
- Imposing a single, combined aggregate lifetime or annual dollar limit
- Imposing an aggregate lifetime dollar limit or annual dollar limit on MH/SUD benefits that is not less than the aggregate lifetime dollar limit or annual dollar limits on medical/surgical benefits; or

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- Where the aggregate annual or lifetime dollar limits differ for categories of medical/surgical benefits, calculating a weighted average aggregate annual or lifetime dollar limit.

Clinical Trial Coverage

Health insurers and group health plans must offer specific coverage for clinical trials as of the first day of the first plan year on or after January 1, 2014. Grandfathered health plans can delay this requirement. The Department will not issue detailed guidance on this provision until further notice. Clinical trial coverage rules require the following:

- Plans may not deny the chance to participate in a clinical trial that meets specific requirements.
- Plans may not deny, limit or impose additional conditions on coverage for routine patient costs in connection with trial.
- Plans cannot discriminate against an employee for participating in a clinical trial.
- Plans will not be required to cover clinical trials out-of-network.
- Plans need to cover only approved clinical trials.

SHOP Marketplace

The Department of Health and Human Services announced a one-year delay in the implementation of online access to the federally facilitated SHOP Marketplace. In 2014, small employers may still use SHOP plans, but will need to enroll directly with the applicable insurer or through an agent or broker. For coverage to begin January 1, the enrollment deadline is Dec. 23 for federally facilitated SHOP plans.

(All the preceding information is not intended to be legal advice just professional interpretation).

A Big Thank You!

On a less complicated subject, I want to wish everyone a very healthy and happy New Year! In addition, our success is due to your continued business, trust and friendship. For that, I sincerely thank you.

My commitment to you in 2014 is to be your best service organization partner. I welcome any feedback you can provide that will help me continue to make IAA the best it can be and meet my commitment to you!

Enjoy the rest of your day and stay healthy!

Thank you,
Paul Kelly, President

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