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BENEFITS BRIEF

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Departments Issue Final ACA Market Reforms Rule

On November 18, 2015, the Departments of Labor, Treasury, and Health and Human Services (the "Departments") published final regulations regarding what are informally known as the Affordable Care Act's ("ACA") "market reforms" (the "Final Rule"). 80 Fed. Reg. 72192. These "market reform" requirements relate to grandfathered health plans, preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, coverage of dependent children to age 26, internal claims and appeal and external review processes, and patient protections under the ACA. The Final Rule finalizes changes to the proposed and interim final rules that were released shortly after passage of the ACA in 2010, and incorporates subregulatory guidance (such as FAQs) issued since publication of the proposed and interim final rules.

The Final Rule applies to group health plans and health insurance issuers beginning on the first day of the first plan year (or, in the individual market, the first day of the first policy year) beginning on or after January 1, 2017.

What Actions You Should Take

The Final Rule finalizes the proposed and interim final rules on the ACA market reforms, and incorporates subregulatory guidance, without substantial change. Nonetheless, the Final Rule includes some important clarifications regarding the market reform rules. As a result, group health plans and health insurance issuers should carefully review the modifications to the market reform rules to determine how those modifications will change the plan or issuer's compliance efforts.

As discussed further below, important clarifications regarding the market reform rules include:

- Adding an Employer to a Grandfathered Multiemployer Plan Will Not Affect Grandfathered Status: The addition of new contributing employer or new group of employees of an existing contributing employer to a grandfathered multiemployer plan will not affect the plan's grandfathered status, provided that the multiemployer plan has not made any other changes that would cause the plan to relinquish grandfathered status.

- Prohibiting HMOs from Excluding Dependents Under Age 26 Because They Live Outside the Service Area: Eligibility restrictions requiring participants to live, work, or reside in the service area violate the ACA, to the extent such restrictions are applicable to dependent children up to age 26.

- Right to Receive New or Additional Evidence or Rationale *Automatically* in Connection with Appeal: Plans and issuers must provide the claimant, free of charge, with new or additional evidence considered relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional

rationale as soon as possible and in advance of the notice of final adverse benefit determination. The Final Rule clarifies that this information must be provided *automatically*. Notice of new information is insufficient.

- Health Reimbursement Account ("HRA") Integration Rules: The Final Rule allows HRA integration with Medicare for employers with fewer than 20 employees that are not required to offer their group health plan coverage to employees who are eligible for Medicare coverage, and clarifies that for purposes of the HRA integration rules generally, forfeiture or waiver occurs even if the forfeited amounts or waived reimbursements may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event).

I. Background

The ACA was enacted in March of 2010. The ACA reorganizes, amends, and adds to the provisions of the Public Health Service Act ("PHSA") relating to group health plans and health insurance issuers in the group and individual markets (the "market reforms"). These market reform provisions are also incorporated into the group health plan requirements in ERISA and the Internal Revenue Code, by reference.

The Departments have issued regulations implementing the revised PHSA Sections 2701 through 2719A in several phases. Throughout 2010, the Departments issued interim final regulations (or temporary and proposed regulations), with requests for comment, implementing ACA Section 1251 (preservation of right to maintain existing coverage), and PHSA Sections 2704 (prohibition of preexisting condition exclusions), 2711 (prohibition on lifetime or annual limits), 2712 (prohibition on rescissions), 2714 (extension of dependent coverage), 2719 (internal claims and appeals and external review process), and 2719A (patient protections).

II. Final Rule

On November 18, 2015, the Departments issued a Final Rule that finalizes changes to the proposed and interim final rules on the ACA's market reforms, and incorporates subregulatory guidance (such as FAQs) issued since publication of the proposed and interim final rules.

Below is a summary of some of the key issues raised by the Final Rule.

Grandfathered Plans

Section 1251 of the ACA and prior guidance issued by the Departments generally provide that certain group health plans and health insurance coverage existing as of March 23, 2010 – *i.e.* grandfathered health plans – are only subject to certain provisions of the ACA (for as long as they maintain that status as grandfathered health plans). This Final Rule is consistent with and incorporates the prior guidance. In addition, it provides several key takeaways on the Departments' current interpretation of this rule.

Key Takeaways on Grandfathered Plans:

1) To maintain status as a grandfathered plan, a group health plan or health insurance coverage must include a statement that it is a grandfathered plan in any summary of benefits, and it must provide contact information for questions and complaints.

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2) The addition of new contributing employer or new group of employees of an existing contributing employer to a grandfathered multiemployer plan will not affect the plan's grandfathered status, provided that the multiemployer plan has not made any other changes that would cause the plan to relinquish grandfathered status.

3) The elimination of "all or substantially all" benefits to diagnose or treat a particular condition will cause a plan or health insurance to lose its grandfathered status. The Departments decline to establish a bright-line test establishing what constitutes "substantially all benefits." This is determined based on all the facts and circumstances.

4) A group health plan (not just a multiemployer plan) that requires either fixed-dollar employee contributions or no employee contributions will not cease to be a grandfathered health plan if the employer contribution rate changes as long as there continues to be no employee contributions or no increase in the fixed-dollar employee contributions towards the cost of coverage and there are no corresponding changes in coverage terms that would otherwise cause the plan to cease to be a grandfathered plan.

Preexisting Condition Exclusions

Section 2704 of the PHSA amends previous rules relating to preexisting condition exclusions and, together with the Departments' prior guidance, provides that a group health plan and a health insurance issuer offering group or individual health insurance coverage generally may not impose any preexisting condition exclusions. This Final Rule is consistent with and incorporates the prior guidance. It does not include any noteworthy revisions or clarifications.

Lifetime and Annual Limits

Section 2711 of the PHSA and prior guidance issued by the Departments generally prohibit annual and lifetime dollar limits on "essential health benefits," as defined in section 1302(b) of the ACA. This Final Rule is consistent with and incorporates the prior guidance. In addition, it includes key takeaways that clarify the definition of "essential health benefits" ("EHB") and the HRA integration rules.

Key Takeaways on Lifetime and Annual Limits:

1) A reasonable interpretation of "essential health benefits" includes only those EHB base-benchmark plans that, in fact, have been selected, whether by active State selection or by default to be the EHB base-benchmark plan for a state, rather than all plans that are potentially authorized.

2) Group health plans and grandfathered individual market coverage that are not required to provide EHBs may select among any of the 51 EHB base-benchmark plans identified in 45 CFR 156.100 and selected by a State or D.C. and the FEHBP base-benchmark plan, as applicable for plan years beginning on or after January 1, 2017, for purposes of determining which benefits cannot be subject to the annual and lifetime dollar limits.

3) Lifetime and annual dollar limits on EHBs are generally prohibited, regardless of whether such benefits are provided on an in-network or out-of-network basis.

4) The annual dollar limit prohibition applies to a health Flexible Spending Account ("health FSA") that is not offered through a cafeteria plan.

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5) The Final Rule clarifies the scope of arrangements that can be integrated with other group health plan coverage by defining "account-based plans" to include health FSAs, medical reimbursement plans, and HRAs.

6) The Departments state that it has come to their attention that there are a wide variety of account based products being marketed, often with subtle but insubstantial differences, in an attempt to circumvent the guidance set forth by the Departments on the application of the annual dollar limit prohibition and the preventive services requirements to account-based plans. The Departments intend to continue to address these specific instances of noncompliance.

7) The Departments clarify that for purposes of the HRA integration rules, forfeiture or waiver occurs even if the forfeited amounts or waived reimbursements may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For this purpose, an HRA is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable (*i.e.*, beginning on the effective date of the election, the participant and participant's beneficiaries have no access to amounts credited to the HRA until the reinstatement event).

8) The Final Rule allows HRA integration with Medicare for employers with fewer than 20 employees that are not required to offer their group health plan coverage to employees who are eligible for Medicare coverage.

Rescissions

Section 2712 of the PHSA and prior guidance issued by the Departments generally provide that group health plans and health insurance issuers offering group or individual health insurance coverage may not rescind coverage except in the event of fraud or intentional misrepresentation of material fact. This Final Rule is consistent with and incorporates the prior guidance. In addition, it provides several key takeaways on the Departments' current interpretation of this rule

Key Takeaways on Rescission:

1) The Departments decline to define "material fact." However, the Departments state that they may provide further guidance if additional questions arise. As such, it seems that plans and issuers may define "material fact" in good faith in a manner consistent with existing guidance.

2) A retroactive cancellation or discontinuance of coverage is not a rescission if it is initiated by an individual and the plan, issuer, employer, or sponsor does not take any actions to influence such individual's decision or to retaliate against such individual.

3) A retroactive cancellation or discontinuance of coverage initiated by the Exchange is not a rescission.

4) Rescissions are subject to internal claims and appeals and external review.

5) A retroactive termination of coverage due to non-payment of COBRA premiums is permissible.

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Dependent Coverage

Section 2714 of the PHSA and prior guidance issued by the Departments generally provide that group health plans and health insurance issuers offering group or individual health insurance coverage that cover children must make such coverage available for children until age 26. This Final Rule is consistent with and incorporates prior guidance. In addition, it includes one key takeaway that may affect eligibility provisions in insured coverage, particularly those in HMO coverage.

Key Takeaway on Dependent Coverage:

1) Eligibility restrictions requiring individuals to work, live or reside in a service area cannot be applied to dependent children up to age 26. However, plans and issuers can continue to provide coverage only within a certain service area. Currently, many insurance issuers impose eligibility restrictions like those addressed in the Final Rule, especially with respect to their HMO coverage. Given the new guidance, plans and policies may need to be updated to bring them into compliance with this rule.

Claims and Appeals

Section 2719 of the PHSA, the DOL's claims and appeals rules, and other prior guidance issued by the Departments provide claims and appeals processes for group health plans and health insurance issuers offering coverage in the group and individual markets. This Final Rule is consistent with and incorporates prior guidance. In addition, it includes important additional guidance on the claims and appeals rules.

Key Takeaways on Claims and Appeals:

1) Plans and issuers must provide the claimant, free of charge, with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale as soon as possible and in advance of the notice of final adverse benefit determination. The Final Rule clarifies that this information must be provided *automatically*. Merely providing a notice informing participants of the availability of such information or rationale is not sufficient.

2) If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond.

3) The NAIC-similar external review process transition period is extended through December 31, 2017. Through this date, State external review processes may be considered to meet minimum standards if they meet the temporary standards for a process similar to the NAIC Uniform Model Act.

4) Determinations of whether a claimant is entitled to a reasonable alternative standard for a reward under a wellness program and determinations of whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act of 2008 and its regulations are considered adverse benefit determinations involving medical judgment. This means that such adverse benefit determinations may be subject to external review.

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5) While the general rule is that plans and coverage must pay for the full cost of an independent review organization ("IRO") for an external review, state external review processes with a nominal filing fee that does not exceed $25 remain valid.

Please note that the Department of Labor has issued proposed regulations on the claims and appeals rules applicable to plans providing disability benefits. These rules are described in more detail in the Groom Law Group alert titled "Department of Labor Issues Proposed Rule That Significantly Alters Claims Procedures for Plans Providing Disability Benefits."

Patient Protections

Section 2719A of the PHSA and prior guidance issued by the Departments provide certain rules regarding the designation of a primary care provider and coverage for emergency services for non-grandfathered group health plans and health insurance issuers offering non-grandfathered group coverage or individual coverage.

Key Takeaways on Patient Protections:

1) The Departments decline to define "primary care provider." Classification of a primary care provider is determined based on the plan or policy terms and in accordance with applicable state law.

2) If a plan or issuer requires the designation of a participating primary care provider for a child, the plan or issuer must allow any physician who specializes in pediatrics (including pediatric subspecialties) who is in-network and available to accept the child to be designated as the primary care provider.

3) All women, regardless of age, are ensured direct access to OB/GYN care.

4) Plans and issuers may apply reasonable and appropriate geographic limitations with respect which participating primary care providers are considered available to be designated as primary care providers.

5) Emergency care is not limited to treatment within 24 hours of the onset of an emergency.

6) A plan or issuer must provide coverage for emergency services that meet the definition of emergency services, without any time limit within which treatment must be sought.

III. Conclusion

The Final Rule finalizes the proposed and interim final rules on the ACA market reforms, and incorporates subregulatory guidance, without substantial change. Nonetheless, the Final Rule includes several important clarifications regarding the market reform rules. As a result, group health plans and health insurance issuers should carefully review the modifications to the market reform rules to determine how those modifications will change the plan or issuer's compliance efforts.

Please contact any of the attorneys in the Health and Welfare Practice Group at Groom Law Group or your regular Groom Law Group attorney for further information.

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