McDermott Will & Emery

Final Regulations on Affordable Care Act Market Reforms

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REGULATORY UPDATE

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Throughout 2010, the U.S. Departments of Health and Human Services, Labor and the Treasury (collectively, the Departments) issued interim final regulations (IFR) implementing ACA market reforms applicable to grandfathered health plan coverage (ACA Section 1251), prohibition of preexisting condition exclusions (Public Health Service Act (PHSA) Section 2704), prohibition on lifetime or annual limits (PHSA Section 2711), extension of dependent coverage (PHSA Section 2712), internal claims and appeals and external review process (PHSA Section 2719), and various other patient protections (PHSA Section 2719A) (collectively, the 2010 Interim Final Regulations). On November 18, 2015, the Departments issued final regulations (the Final Regulations) on all topics in the 2010 Interim Final Regulations. McDermott Will & Emery LLP's coverage of the 2010 Interim Final Regulations can be found below:

Grandfathered Health Plan Interim Final Regulations

Preexisting Condition Exclusions, Lifetime and Annual Limits Interim, Rescissions, and Patient Protections Interim Final Regulations

Claims and Appeals Interim Final Regulations

The Final Regulations generally adopt the rules of the 2010 Interim Final Regulations (IFR) without substantial change, and incorporate clarifications issued to date in various forms of sub-regulatory guidance. The following includes a high level overview of the finalized rules and new clarifications under the Final Regulations.

Grandfathered Health Plans

Section 1251 of the ACA provides that certain group health plans and health insurance coverage existing as of March 23, 2010 (grandfathered health plans) are only subject to certain provisions of the ACA. For a summary of the application of provisions to grandfathered health plans, see https://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf. The Final Regulations incorporate the IFR on grandfathered health plan coverage, as amended, as well as clarifications issued in sub-regulatory guidance. (See ACA Implementation Frequently Asked Questions (FAQs) Parts I, II, IV, V, and VI.)

1. Definition: The determination of grandfathered status applies separately with respect to each benefit package. If a plan offers three benefit package options — a PPO, POS, and an HMO — each benefit option is treated as a separate benefit package. If any of the benefit packages cease to maintain grandfathered status, this will not affect the grandfathered status of the other benefit packages.
2. Disclosure: To maintain status as a grandfathered health plan, a plan or coverage must include a statement that the plan or coverage believes it is a grandfathered health plan in any summary of benefits provided under the plan. The Final Regulations retain the model disclosure language of the IFR.
3. Anti-Abuse Rules:

- *Plan Transfers*: A plan transferring employees will lose grandfathered status if, treating the transferee plan as if it were an amendment of the transferor plan, such amendment would cause a loss of grandfathered status and there is no bona fide employment-based reason to transfer the employees into the transferee plan.
- **CLARIFICATION**: The addition of a new contributing employer or new group of employees of an existing contributing employer to a grandfathered multiemployer health 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 its grandfathered status.

4. Maintenance of Grandfathered Status:

- *Elimination of All or Substantially All Benefits*: The elimination of all, or substantially all, benefits to diagnose or treat a particular condition will cause a plan or coverage to relinquish its grandfathered status. This determination is made based on all the facts and circumstances, taking into account the items and services covered for a particular condition under the plan on March 23, 2010, as compared to the items and services covered at the time the plan makes the benefit change effective.
- *Increase in Fixed Amount Copayments*: A change to a

copayment level for a category of services that exceeds the standards set forth in the IFR will cause a plan to lose its grandfathered status, even if a plan retains the level of copayment for other categories of services. Each change in cost-sharing must be separately evaluated under the standards set forth in the regulations.

- *Decrease in Contribution Rate by Employers and Employee Organization*: A decrease in the employer contribution rate for coverage under a plan or coverage beyond the permitted percentage in the IFR and subsequent guidance will result in loss of grandfathered status. There continue to be two rules related to decreases, one for a contribution based on the cost of coverage, and one for a contribution based on a formula.
- *Changes in Annual Limits*: The Final Regulations adopt the rules from the IFR regarding three different limit-related situations that would cause a plan or coverage to relinquish its grandfathered status.
- *Changes to Fixed Amount Cost-Sharing Based on a Formula*: If a plan or coverage has a fixed amount cost-sharing requirement other than a copayment (*e.g.*, deductible or out-of-pocket limit) that is based on a percentage-of-compensation formula, that cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan as long as the formula remains the same as that which was in effect on March 23, 2010.
- *Grandfathered Status and Wellness Programs*: Plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors by participants and beneficiaries; however, penalties should be examined carefully by plan sponsors so as to not trigger impermissible changes to fixed amount cost-sharing that could result in a loss of grandfathered status.
- *Changes to Multi-Tiered Prescription Drug Formularies*: If a drug was classified in a tier as a brand-name drug with no generic available, and a generic alternative for the drug becomes available and is added to the formulary, moving the brand-name drug to a higher tier would not cause the plan or coverage to relinquish grandfathered status.
- *Clarifications on Timing of the Loss of Grandfathered Status*: A plan or coverage will cease to be a grandfathered health plan when an amendment to plan terms that exceeds the permitted cost-sharing threshold of the Final Regulations becomes effective, regardless of when the amendment is adopted. There is no opportunity to cure the loss of grandfathered status.

Prohibition of Preexisting Condition Exclusions:

PHSA Section 2704 provides that a group health plan and a health insurance issuer may not impose any preexisting condition exclusions with respect to group or individual health insurance coverage. The Final Regulations incorporate the IFR regarding the prohibition on preexisting condition exclusions without substantial change, and incorporate clarifications issued to date in subsequent guidance (See FAQs Part V, Q6).

Prohibition on Lifetime and Annual Limits:

PHSA Section 2711 generally prohibits annual and lifetime dollar limits on essential health benefits. The Final Regulations adopt the IFR without substantial change and incorporate certain pertinent clarifications issued thus far in sub-regulatory guidance.

1. Definition of Essential Health Benefits: Under the Final Regulations, self-insured, large group market, and grandfathered health plans that are not required to provide essential health benefits (EHB) may select among any of the 51 EHB base-benchmark plans selected by a state or the District of Columbia and the Federal Employees Health Benefit Program base-benchmark plan, as applicable for the 2017 plan year, for purposes of determining which benefits cannot be subject to annual or lifetime dollar limits. The current list of the 51 proposed EHB base-benchmark plans selected by the states for 2017 can be found at

https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

2. Out-of-Network Benefits: Lifetime and annual dollar limits on EHB are generally prohibited, regardless of whether such benefits are provided on an in-network or out-of-network basis.

3. Health Reimbursement Accounts (HRAs) and Other Account Based Plans:

- **CLARIFICATION**: An account based plan is an employer-provided group health plan that provides reimbursements of medical expenses (other than individual market policy premiums), subject to a maximum fixed dollar amount for a period (*e.g.*, HRAs, health FSAs and medical reimbursement plans that are not HRAs).
- If an HRA is "integrated" with other group health plan coverage, and the other group health plan coverage complies with the prohibition on annual or lifetime limits, the combined arrangement satisfies the requirements even though the HRA imposes a dollar limit.
- The basic principles for when an HRA is considered "integrated" are included in the Final Regulations. Each integration method requires that a participant must be permitted to (1) permanently opt out of and waive future reimbursements from the account-based plan at least annually, and (2) forfeit remaining funds upon termination or opt out of and waive future reimbursements under the plan.
- **CLARIFICATION**: 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. However, the forfeiture or waiver must be irrevocable until the reinstatement date.
- **CLARIFICATION**: The Final Regulations contain a special rule for employers with fewer than 20 employees that are not required to offer group health plan coverage to employees who are eligible for Medicare coverage, and that do offer group health plan coverage to their employees who are not eligible for Medicare, but not to their employees who are Medicare-eligible. In this case, a premium reimbursement arrangement for Medicare Part B or D premiums may be integrated with Medicare and deemed to satisfy the annual dollar limit prohibition and the preventive services requirements if the employees who are not offered the other group health plan coverage would be eligible for that plan but for their eligibility for Medicare.
- **IMPORTANT NOTE**: The Final Regulations do not incorporate all of the other sub-regulatory guidance due to the Departments' concern that some of the different account-based products being marketed are intended to circumvent the Departments' guidance on the application of the annual dollar limit prohibition and the preventive services requirements to account-based plans. The Departments plan to continue to address these specific instances of noncompliance in the future.

Prohibition on Rescissions

PHSA Section 2712 provides that a plan or issuer offering health insurance coverage must not rescind coverage unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. The Final Regulations adopt the IFR without substantial change and incorporate clarifications issued to date in subsequent guidance (See FAQs Part II, Q7).

1. Definition of Rescission: A rescission is a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it has only a prospective effect or to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. A rescission is not prohibited if a covered individual commits fraud or makes an intentional misrepresentation of material fact. **NOTE**: The Final Regulations decline to define "material fact."

2. Scope and Application: The statutory prohibition on rescissions precludes plans and issuers from rescinding coverage under any circumstances *except as* provided in the statute or regulations.

3. Termination of Coverage Initiated by Participant,

Beneficiary, or Enrollee: **CLARIFICATION**: A retroactive cancellation or discontinuance of coverage is not a rescission if (1) it is initiated by the individual (or an authorized representative) and the employer, sponsor, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision or otherwise retaliate against the individual; or (2) it is initiated by the Exchange pursuant to the rules regarding enrollee-initiated terminations.

4. Interaction with Internal Appeals and External Review: Rescissions are eligible for internal claims and appeals and external review for non-grandfathered health plans. Plan coverage must remain effective pending the outcome of an internal appeal.

5. Interaction with COBRA Continuation Coverage: **CLARIFICATION**: The exception to the prohibition on rescission for failure to timely pay required premiums or contributions toward the cost of coverage also includes failure to timely pay required premiums towards the cost of COBRA continuation coverage.

6. Notice of Rescission: A plan or issuer must provide at least 30 calendar days advance written notice to each participant who would be affected before coverage may be rescinded (where permitted). **NOTE**: The Final Regulations encourage plans to coordinate notices related to rescissions and appeal procedures to the extent possible.

Coverage of Dependents to Age 26

PHSA Section 2714 provides that a plan or issuer offering dependent coverage must make such coverage available for children until attainment of age 26. The Final Regulations adopt the IFR without substantial change and incorporate clarifications issued to date in sub-regulatory guidance (See FAQs Part I and V).

1. Definition of Dependent: **CLARIFICATION**: The Final Regulations do not permit eligibility provisions under a plan or coverage based on service area, to the extent such restrictions are applicable to dependent children up to age 26, even if such restrictions are intended to apply generally to all participants and beneficiaries under the plan. Thus, plans that use an HMO design that imposes restrictions on eligibility that require a participant and beneficiaries to work, live or reside in the HMO service area will need to be reexamined to permit dependent eligibility if a dependent child covered under the parent's plan moves out of the HMO's service area (*e.g.*, to attend college).

2. Definition of Child: A plan or issuer will not fail to satisfy the dependent coverage provision merely because it conditions health coverage on support, residency, or other dependency factors for individuals under age 26 who are not described in Section 152(f)(1) of the Code (*e.g.*, a grandchild or niece). For these individuals, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

3. Uniformity Irrespective of Age: A plan may not limit benefit packages offered based on the age of dependent children. However, distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children, are permitted.

Internal Claims and Appeals and External Review

PHSA Section 2719 provides that non-grandfathered plans must comply with certain standards regarding internal claims and appeals and external review. The Final Regulations adopt the IFR, as amended, without substantial change and codify some of the enforcement safe harbors, transition relief, and clarifications set forth in subsequent guidance issued by the Departments. **NOTE**: In conjunction with the issuance of these final regulations, the DOL issued proposed regulations to amend the DOL claims procedure regulations as applied to plans providing disability benefits (http://www.mwe.com/DOLs-New-Disability-Claim-Rules-Add-to-a-Plan-Administrators-Duties-under-Welfare-and-Retirement-Benefit-Plans-11-30-2015/).

1. Full and Fair Review of Internal Claims and Appeals:

Plans and issuers must provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan or issuer in connection with the claim, as well as any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of the final adverse benefit determination is required to be provided under the DOL claims procedure regulations. **CLARIFICATION**: The new or additional evidence or rational must be provided automatically, and 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.

2. Culturally and Linguistically Appropriate Standard: The Final Regulations retain the culturally and linguistically appropriate standards (CLAS) requirements as set forth in the amendment to the interim final regulations.

3. Extension of the Transition Period for State External Review Processes: The Final Regulations extend the National Association of Insurance Commissioners (NAIC) similar external review process transition period so that the last day of the transition period is December 31, 2017. Until then, an applicable state external review process applicable to an issuer or plan may be considered to meet the minimum consumer protection standards set forth in the IFR. Once the transition period has ended, plans and issuers in a state that has not implemented the NAIC parallel external review process will be required to comply with a federal external review process.

4. Scope of Federal External Review Process: Federal external review may be used for only for an adverse benefit determination that involves medical judgment as determined by the external reviewer, or a rescission of coverage. **CLARIFICATION**: The Final Regulations add two items to the list of adverse benefit determinations that involve medical judgment (as set forth in the IFR): (1) a plan's or issuer's determination of whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program, and (2) a plan's or issuer's determination of whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations.

5. Federal External Review Process for Self-Insured Group Health Plans: Non-grandfathered self-insured plans may comply with the external review process outlined in the Final Regulations or a state external review process if the state chooses to expand access to their state external review process to plans that are not subject to state laws. Plans may also elect to use the private accredited IRO process for external review or the federally administered external review process administered by HHS.

6. Filing Fees for External Review: Filing fees for external review are generally prohibited, but the Final Regulations do not invalidate existing state external review processes because they permit a nominal filing fee, consistent with the NAIC model. To be considered nominal, the filing fee must: (1) not exceed $25, (2) be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, and (3) be waived if payment of the fee would impose an undue financial hardship. The annual limit on filing fees for any claimant within a single plan year must not exceed $75.

Patient Protections

PHSA Section 2719A provides certain patient protections under the ACA. The Final Regulations incorporate the IFR without substantial change and incorporate clarifications issued to date in sub-regulatory guidance (See FAQs Part I Q15).

1. Choice of Healthcare Professional:

- **NOTE**: The Departments declined to add language to address cases of incapacity, but noted that a duly authorized representative may act on behalf of a

participant or beneficiary to the extent permitted under other applicable federal and state laws.

- **CLARIFICATION**: If a plan or issuer requires or provides for the designation of a participating primary care provider for a child, the plan or issuer must permit the designation of any physician who specializes in pediatrics, including pediatric sub-specialties.
- **CLARIFICATION**: All women regardless of age may receive obstetrical and gynecological care without prior authorization or referral by the plan, issuer or primary care provider.

2. Emergency Services:

- *Additional Administrative Requirements*: A plan or coverage with a network of providers that provide benefits for emergency services may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.
- *Out-of-Network Cost-Sharing Requirements*: While patients may be subject to balance billing, the plan or issuer must pay a reasonable amount for emergency services by some objective standard before a patient becomes responsible for balance billing. The Final Regulations incorporate the IFR regarding what constitutes a reasonable amount, as well as participant notice requirements regarding balance billing.
- *No Time Limit*: **CLARIFICATION**: A plan or issuer cannot require a time limit (*e.g.*, 24 hours) within which a participant must seek emergency services and the plan or issuer must provide coverage for any emergency services that meet the definition of emergency services under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act.

Next Steps

These final regulations apply to self-insured and insured group health plans beginning on the first day of the first plan year beginning on or after January 1, 2017. Plan sponsors should review the rules and clarifications to ensure that plan design and documentation, administrative procedures, and participant communications will be compliant with the Final Regulations. Revisions to plan design, administrative procedures and amendments to documentation should be completed during the 2016 plan year.

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