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REFORM UPDATE

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FINAL REGULATIONS ON MARKET REFORM RULES

The Departments of Labor (DOL), Treasury and Health Human Services (HHS) published final regulations on the market reform rules of the Affordable Care Act (ACA), including:

- Grandfathered plan rules
- Elimination of the pre-existing condition limitations
- Lifetime and annual dollar limitation rules
- Coverage recession rules
- Requirement to cover children to age 26
- Internal claim process/appeal rules and external review requirements
- Patient protection provisions

These final rules update the regulations by removing provisions no longer applicable and by incorporating clarifications made during the last several years.

GRANDFATHERED PLAN RULES

The ACA provided that certain group health plans and health insurance coverage in place as of March 23, 2010 would be exempt from compliance with certain aspects of the law until the point when they lost "grandfathered" status. This delay of effective dates applies to the following ACA requirements:

- Non-discrimination rules for fully insured plans (currently delayed for all insured plans until additional guidance is issued)
- Specific expanded preventive care services with no member cost-sharing (this includes the expanded well-woman services)
- New claim rules and appeal procedure requirements
- Primary care physician designation rules (applies only to plans requiring a member to designate a primary care physician)
- Emergency room coverage rules regarding the use of out-of-network providers

- Requirement to cover specific clinical trials
- Requirement to cap out-of-pocket costs to maximum limits that are annually indexed. All employee cost-sharing for essential health benefits must accumulate toward the maximum.

Any of the following actions can trigger a loss of grandfathered status:

- Eliminate all or substantially all benefits to diagnose or treat a particular condition
- Increase, in any way, a percentage cost-sharing requirement (i.e., coinsurance) above the level that was in effect on March 23, 2010
- Increase fixed cost-sharing requirements other than copayments, such as deductibles, by a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percent
- Increase copayments by an amount that exceeds the greater of:
    a) A total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percent; or
    b) $5 increased by medical inflation measured from March 23, 2010
- For a group health plan, decreasing the employer contribution rate by more than five percentage points below the rate on March 23, 2010. The decrease is based on the cost of coverage and applies separately to the cost at any coverage tier for any class of similarly-situated individuals.
- Implementing specific changes to make annual dollar limits more restrictive (these limitations are no longer permitted on essential health benefits)

More information on grandfathered plans can be found at http://www.mcgrawwentworth.com/Reform_Update/2010/Reform_Update_10.pdf.

To determine if grandfathered status was lost, employers had to measure plan changes back to the plan design in effect on March 23, 2010. Employers need to review plan and/or contribution changes each year to make sure they do not exceed the parameters that prompt the loss of grandfathered status. If you still have a grandfathered plan, the current DOL audit requests the review of changes to prove grandfathered status is maintained.

The final regulations:

- Clarify that adding an employer to a grandfathered multiemployer plan will not affect the plan's grandfathered status. This assumes the multiemployer plan administrator has not made any changes that would prompt the loss of grandfathered status, such as increasing cost-sharing beyond the permitted limits.
- Remove the requirement that a change in insurance carrier or third-party administrator would automatically result in a loss of grandfathered status. This was changed back in 2010, but needed to be officially addressed in the regulations.

- Confirm that a health plan must include a statement that it is a grandfathered plan in any summary of benefits, and must provide contact information for questions or complaints.
- Provide a detailed discussion of one particular trigger to lose grandfathered status, the elimination of all or substantially all benefits to diagnosis or treat a condition. Health plans wanted the final regulations to provide guidance on what might be considered the elimination of substantially all benefits to treat a condition. The Departments have maintained that this will remain a "facts and circumstances" determination.

Not many plans have been able to maintain grandfathered status. It would be difficult to absorb five years of increases without making any plan or contribution changes that result in the loss of grandfathered status. However, some plans have managed to do this. It is important to analyze any plan or contribution changes each year to confirm whether grandfathered status still applies.

ELIMINATION OF THE PRE-EXISTING CONDITION LIMITATIONS

The ACA defines a pre-existing condition as a limitation or exclusion of benefits related to a health condition that was present before the date of enrollment for coverage.

The exclusions for pre-existing condition limitations were implemented in two parts. The first part prohibited pre-existing condition limitations on enrollees younger than 19 years of age. This was effective as of the first day of the first plan year beginning on or after September 23, 2010. The second part prohibited pre-existing condition limitations for any plan member. This applied to plans as of the first day of the first plan year beginning on or after January 1, 2014.

It was fairly easy for plans to remove explicit pre-existing condition limitations. However, employers do need to review their plans to determine if there are any implicit pre-existing condition limitations. For example, if a plan excludes coverage for treatment of an injury received prior to the effective date of coverage, this is viewed as an implicit pre-existing condition limitation. This provision would have to be removed to comply with the ACA.

The pre-existing condition limitation rules were largely adopted as proposed. The distinction made for enrollees under age 19 has since been removed, as the pre-existing condition limitations can no longer be applied to any member, regardless of age.

LIFETIME AND ANNUAL DOLLAR LIMITATION RULES

The lifetime and annual dollar limitations were updated to reflect their current status. The regulations no longer needed to refer to the scaled-up annual dollar limitations included in the statute. Health plans cannot apply any annual or lifetime dollar limitations to coverage for essential health benefits.

A number of clarifications were made in regard to this requirement:

- A clarification was provided on the definition of essential health benefits (EHB). For self-funded plans, employers have struggled with how to define essential health benefits when every state selects or is defaulted to a benchmark EHB plan. A reasonable interpretation of essential health benefits is simply to use a plan selected by a state. The process for determining the benchmark EHB plan is discussed in our *Reform Update* at

http://www.mcgrawwentworth.com/Reform_Update/2013/Reform_Update_53.pdf.

For large or self-funded employers, essential health benefits only affect the lifetime and annual dollar limitation rules. (Large employers are typically those with 50 or more full-time equivalent employees.) A large employer that fully insures the health plan is not required to cover essential health benefits. Similarly, self-funded plans of any size are not required to cover essential health benefits. For plan years beginning on or after January 1, 2017, an employer can rely on any state-selected EHB benchmark plan, or use the Federal Employee Health Benefit Plan, to determine which benefits cannot be subject to annual or lifetime dollar limits.

- The prohibition on lifetime or annual dollar limits for EHBs applies on both an in-network and out-of-network basis.
- The ban on annual limits does not apply to health flexible spending accounts.
- A clarification was made to the integration rules related to health reimbursement arrangements (HRAs). For active employees, HRAs are required to be integrated with an HRA-compliant comprehensive health plan that meets the ACA's market reform rules. The final rules will allow an HRA to be integrated with Medicare for employers **with fewer than 20 employees (based on IRS control group rules)**. Such small employers are not required to offer their health plan coverage to employees who are eligible for Medicare.
- Since HRAs must be integrated, some employers are struggling with how to handle HRA balances when someone loses coverage under the comprehensive health plan. The employer could always require forfeiture. The final rules clarify that forfeiture or waiver of amounts in the HRA will not count, even if the amounts can be reinstated upon a fixed date or a participant's death. This simply means an employee can forfeit an HRA balance, when not a part of an integrated plan, and then have that balance reinstated at a future date if the plan permits it. Please note that integrated plans are not required when the HRA covers fewer than two active employees. Thus, the balances could be reinstated in a retiree-only HRA.

Most employer plans already comply with these requirements, as the final regulations reflect guidance issued to date. However, employers should check their plans to make sure they are not applying lifetime or annual dollar limits to EHBs in- or out-of-network.

COVERAGE RESCISSION RULES

The ACA does not allow health plans to retroactively terminate coverage, which is considered a coverage rescission. Coverage rescissions are allowed in cases of fraud or intentional misrepresentation of material fact. A termination of coverage with a retroactive effect, if due to a failure to pay premiums or required contributions for coverage, is not a rescission.

The final rules adopted much of what was included in the proposed rules. However, some additional details were provided:

- Health plans are required to determine a material fact in a good-faith interpretation of existing guidance. (The Departments may provide clarifying guidance if they continue to

receive questions). An example of a misrepresentation of a material fact is included. Assume an applicant provides false or inaccurate information about tobacco use. In this situation, a plan could not retroactively terminate coverage due to a misrepresentation of a material fact. A plan could instead retroactively charge premiums to reflect tobacco-user status.

- A retroactive termination is not a rescission if it is initiated by an individual and the plan did not take action to influence the individual to retroactively terminate coverage.
- Rescissions are subject to the internal claims and appeal rules. They are also subject to the external review rules added by the ACA.
- A retroactive termination of COBRA coverage due to non-payment of premiums is not a rescission and is permitted.

Before coverage may be rescinded, a plan must provide advance written notice of at least 30 calendar days to affected individuals.

REQUIREMENT TO COVER CHILDREN TO AGE 26

The rules regarding dependent child coverage were largely adopted without change. If a plan offers coverage to dependent children, coverage must be extended until the child attains age 26. Please note that the employer mandate rules require employers to offer dependent coverage until the end of the month in which the child turns 26, to avoid penalties. Eligibility for dependent child coverage must be based solely on the relationship between the employee and the child. A plan cannot restrict eligibility to a dependent child under age 26 because of financial dependency, residency, student status, employment or any combination of these factors. Further, a plan cannot restrict eligibility based on the child's marital status or eligibility for other health coverage.

Important clarification was provided for plans that require members to live within a service area in order to be eligible for coverage. This is a common provision in HMO plans, but applying this provision to dependents up to age 26 violates the ACA. Although HMO plans cannot refuse to cover dependent children living outside the service area, the rules of the HMO still apply. Therefore, the dependent would need to seek care from a primary care physician within the HMO network. Emergency care can be provided according to the terms of the plan.

INTERNAL CLAIM PROCESS/APPEAL RULES AND EXTERNAL REVIEW

The final regulations adopted many of the proposed rules, but a number of important clarifications and new provisions were added:

- Claimants are now required to automatically receive, free of charge, any new evidence or rationale related to their appeals. It must be provided if the new evidence or rationale was considered, relied upon or generated by the plan in connection with the claim or appeal. The new evidence or rationale must be provided as soon as possible, and in advance of the final benefit determination. Simply notifying the claimant that new information exists is insufficient.

- If the new evidence or rationale is received so late that it would be impossible to provide to the claimant in time for that individual to have a reasonable opportunity to respond, then the final adverse benefit determination time period is tolled until the claimant has a reasonable opportunity to respond.
- States will have until December 31, 2017 to transition to an NAIC-similar external review process. Until that date, state external review standards will be deemed to have met minimum standards as long as they meet the temporary standards.
- The definition of an adverse benefit determination is expanded. Going forward, it will include determinations to assess whether an individual is entitled to a reasonable alternative standard to receive a reward under a wellness program. It will also include determinations regarding plan compliance with the non-quantitative treatment limitations under the Mental Health Parity and Addiction Equity Act of 2008. These will be considered adverse benefit determinations because they involve a medical judgment. It also means they may be subject to external review.
- If a plan contracts with an independent review organization (IRO) for external reviews, the plan is required to pay the full cost of the reviews. However, if the state review process is used instead, and the state charges a nominal filing (i.e., no more than $25), then the claimant can be required to pay the state's nominal filing fee.

Typically, your insurance carrier or third-party administrator (TPA) will handle both the internal claim process and internal appeals. They will adopt any necessary changes. Insurance carriers are responsible for handling the external review for fully-insured plans. If your plan is self-funded, you should check with your TPA on the process that will be used for external reviews.

PATIENT PROTECTION PROVISIONS

The patient protection rules under the ACA encompass the rules surrounding primary care physician designations and coverage for emergency room services. These apply only to non-grandfathered plans. The following clarifications were made in the final regulations:

- The Departments were asked to define what types of doctors should be considered primary care physicians. The Departments declined to make designations, and instead defer to the plan or policy language to define who is considered a primary care physician.
- If the plan requires the designation of a primary care physician for a child, then the plan must allow any provider that specializes in pediatrics (including pediatric sub-specialties) that is in the network and available to accept the child as a patient.
- All women must have direct access to an obstetrician/gynecologist.
- Plans are permitted to apply reasonable and appropriate geographic limitations to participating providers that can be designated as primary care providers.

Two clarifications were made in terms of coverage for emergency care:

- Emergency care cannot be defined as care received within 24 hours of an emergency.

- A plan must cover services that meet the definition of emergency services without any time limits placed on when treatment must be sought.

For the most part, health plan vendors will meet the requirements. However, employers need to understand the rules to confirm their plans are complying with these patient protection rules of the ACA.

CONCLUDING THOUGHTS

Many of the market reform aspects of the ACA were the first health care reform requirements to affect employers. Given the tight timing between the passage of the ACA and the effective dates of these market reform provisions, initial guidance was released in proposed or interim final status. Clarifications were made over the last five years through IRS Notices, Frequently Asked Questions and other memorandums. These final regulations do not include substantial changes. Rather, they confirm and reflect the current understanding of the market reform rules.