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update

Public Sector Benefits Compliance News

December 16, 2015

Departments Release Series of Final Rules Under the Affordable Care Act

The Departments of Labor, Treasury, and Health and Human Services (the "Departments"), which are responsible for implementing group health plan standards under the Affordable Care Act,[1] recently published a series of final rules implementing various requirements under the Act.[2] For the most part, the final rules codify as regulations multiple rules and answers to Frequently Asked Questions that the Departments have issued since 2010. This *Update* highlights new positions on important issues not addressed by the Departments in previous guidance. The new final rules apply to plan years beginning on or after January 1, 2017.

Annual and Lifetime Dollar Limits

The Affordable Care Act prohibits group health plans from imposing annual or lifetime dollar limits on "essential health benefits" (EHB). In general, that term encompasses hospital and ambulatory care services, emergency services, maternity and newborn care, pediatric services, laboratory services, mental health and substance use disorder services, prescription drugs, preventive services, chronic disease management, and rehabilitative and habilitative services and devices. However, the precise definition of "essential health benefits" varies from state to state. Plan sponsors of self-insured plans do not have to cover all EHBs, but if they provide the benefit, the plan cannot have or add annual or lifetime dollar limits on them. Consequently, if plan sponsors have annual or dollar limits on a benefit they must assure that it is not an essential health benefit.[3] The Departments clarified that lifetime and annual dollar limits on EHB are prohibited, regardless of whether such benefits are provided on an in-network or out-of-network basis.

Plan sponsors have until the 2017 plan year to remove any dollar limits on essential health benefits provided out of network.

Health Compliance News Highlights:

- These final rules primarily codify guidance previously issued, but some new rules are announced.
- Going forward, annual or lifetime dollar limits are prohibited whether the benefit is provided in network or out of network.
- Plan sponsors gain new flexibility to suspend Health Reimbursement Arrangement (HRA) balances rather than providing for permanent forfeiture.
- Plan sponsors cannot require children under 26 to live or work in the service area of a health maintenance organization (HMO) or other network.

[1] The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

[2] The final rules were published in the November 18, 2015 *Federal Register*.

[3] Plan sponsors make this determination by selecting a "benchmark" plan among authorized benchmark plans and applying that benchmark plan's definition of essential health benefits. These final rules clarify that plan sponsors must select one of the benchmark plans adopted by a state (or selected by HHS for that state in the absence of a state election) or one of three plans available nationwide through the Federal Employees Health Benefits Program.

Account-Based Plans

Account-based plans are group health plans that provide reimbursement of medical expenses, such as Health Reimbursement Arrangements (HRAs). The final rules codify guidance released starting in 2013 relating to account-based plans. In general, plan sponsors cannot offer an account-based plan such as an HRA on a stand-alone basis unless the plan is a retiree-only plan.[4] This is because a stand-alone HRA imposes an annual dollar limit on essential health benefits and thus violates the prohibition of such limits discussed above. As a result, an HRA can be offered only to individuals who also enroll in group health coverage other than the HRA.

In addition, plan sponsors must offer employees (or former employees) the ability to permanently opt out of and waive future reimbursements from the HRA at least once per year and upon termination of employment.

The new rules permit the waived HRA balance to be reinstated upon a fixed date, a participant's death, or the earlier of the two. The employee's or former employee's election to forfeit or waive the balance must be irrevocable until the reinstatement event. This means that the employee or former employee cannot have access to the balance prior to reinstatement and, upon reinstatement, cannot submit for reimbursement any claims incurred after the forfeiture and prior to the reinstatement. By using this option, employees or former employees could, for example, reinstate their HRA balance when they become eligible for Medicare (and thus no longer qualify for tax credits when they purchase Exchange/Marketplace coverage). The balance could also be used by eligible family members if the balance is reinstated upon death.

Children Under Age 26

The Affordable Care Act requires that plan sponsors continue dependent coverage until a child turns 26. In general, this means that plan sponsors cannot apply eligibility requirements other than relationship to the employee and age. Plan sponsors also cannot vary the terms of the plan based on age of a child (except for a child age 26 or older).

The new final rule adds another item to the list of prohibited eligibility requirements: plans cannot restrict eligibility to a child who lives, works or resides in an HMO service area or other network service area, even if the restrictions otherwise apply to all participants and dependents under the plan. For example, if a child cannot be covered under a parent's plan if he or she moves out of an HMO service area to attend college, then the plan's rule would violate the Act.

Grandfathered Status

Existing rules set out a list of plan design changes that cause a plan to lose its grandfathered status (*e.g.*, raising coinsurance by any amount).[5] The final rules continue to require that to retain grandfathered status, a group health plan or health insurer must include a statement that the plan or health insurer believes it is a grandfathered health plan in any summary of benefits provided under the plan.

Once a plan loses its grandfathered status, additional requirements (such as the requirement to provide certain preventive services without cost sharing) apply. The new final rule clarifies that multiemployer plans can add new contributing employers or new groups of employees of an existing contributing employer to the plan without losing grandfathered status.

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[4] A retiree-only plan may offer a stand-alone HRA because a retiree-only plan is exempt from the prohibition on annual dollar limits and other group health plan standards.

[5] For background, see Segal Consulting's March 2013 *Health Care Reform Insight*, "The Consequences of Losing 'Grandfathered' Status."

Emergency Services

The Affordable Care Act requires that non-grandfathered plans adhere to certain requirements if they cover emergency services in the emergency department of a hospital. One of those requirements is designed to protect patients from balance-billed charges when they obtain out-of-network emergency services. This requirement minimizes the amount of balance-billed charges by requiring that plans pay a reasonable amount to out-of-network providers of emergency services. Existing regulations require that plans pay *the greater of* the following:

- The amount negotiated with in-network providers (excluding in-network cost sharing), with special rules that govern when there is more than one amount that the plan has negotiated with its network providers;
- The amount the plan would pay under its usual payment formula for out-of-network providers (excluding in-network cost sharing); or
- The amount that would be paid under Medicare for the service (excluding any in-network cost sharing).

The new final rule states that these minimum payment standards do not apply in cases where state law prohibits a patient from being required to pay balance-billed charges or where the plan is contractually responsible for such charges. However, group health plans and health insurers are required to provide patients with adequate and prominent notice of their lack of financial responsibility with respect to such charges to prevent inadvertent payment by the patient.

Internal Claims and Appeals and External Review

The Affordable Care Act requires that non-grandfathered plans comply with revised rules governing claims and appeals and provide for external review of certain adverse benefit determinations. In general, the new final rule adopts positions taken in previous guidance, with a few changes.

- ***Internal Claims and Appeals*** Plan sponsors continue to be required to provide claimants automatically with any new or additional evidence or rationale upon which the plan sponsor may rely. Under the new final rule, if the plan sponsor receives new or additional evidence so late in the process that claimants would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has such an opportunity.
- ***External Review*** Under the new final rule, determinations involving medical judgment or a rescission of coverage continue to be subject to external review. In a change from earlier rules, the new final rule generally prohibits plan sponsors from charging claimants even a nominal filing fee for external review. The only exception is plans or insurers subject to state laws that permit filing fees. Such plans or insurers may continue to require a filing fee that does not exceed $25, subject to rules that require a refund or waiver in certain situations. Finally, state and local governmental plans will have additional time — through December 31, 2017 — to use state external review processes that are similar to external review standards adopted by the National Association of Insurance Commissioners (NAIC). (That deadline was previously set to expire December 31, 2015.)[6]

[6] According to HHS, most states have external review processes that parallel the NAIC requirements, but 10 states have processes that are similar to, but do not parallel, the NAIC standards: Arizona, Delaware, District of Columbia, Indiana, Kansas, Massachusetts, Michigan, New Mexico, Texas and Wyoming. Plan sponsors of state and local governmental plans also have the option to use an HHS-administered external review process or to contract (directly or through their third-party administrators) with three Independent Review Organizations (IROs).

Pediatric Specialists

The Affordable Care Act imposes certain requirements on non-grandfathered plans that require employees to select a primary care provider. One requirement is that parents be allowed to select a pediatrician as the primary care provider for a child. The new final rule includes pediatric subspecialists as a type of provider whom parents may select.

Implications for Plan Sponsors

Plan sponsors should thoroughly review plan documents and operations to ensure the plan is complying with all applicable requirements. Special attention should be paid to any remaining annual or lifetime dollar limits and any plan provisions that apply differently to children based on their age. Plan sponsors of non-grandfathered plans should also review the plan's terms and operations with respect to emergency services and claims and appeals. Plan sponsors with account-based arrangements should review those arrangements carefully and consider adding the flexibility offered by the new reinstatement rule.

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If you would like additional information about this news, please contact your Segal consultant or the Segal office nearest you. Segal can be retained to work with plan sponsors and their legal counsel on compliance issues.

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