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# Departments Finalize Market Mandate Guidance

The Departments of Labor, Treasury, and Health and Human Services (the departments) issued final regulations in November addressing grandfathered health plans, preexisting condition exclusions, lifetime and annual dollar limits, rescissions, coverage of dependent children to age 26, processes for internal claims and appeals, external review processes, and patient protections requirements. These final regulations reflect comments, subregulatory guidance, and proposed and interim final rules (dating back to 2010). Compliance is required by the beginning of the 2017 plan year.



## Background

Since 2010, the departments have issued a variety of guidance on the ACA's market mandates and insurance reforms — interim final regulations, temporary and proposed regulations, FAQs, and various requests for comments. Topics included the:

- Preservation of right to maintain existing coverage
- Prohibition of preexisting condition exclusions
- Prohibition on lifetime or annual limits
- Prohibition on rescissions
- Extension of dependent coverage
- Internal claims and appeals and external review process
- Patient protections

Late in 2015, the departments issued regulations that finalize changes to the proposed and interim final regulations on market reforms and incorporate subregulatory guidance (such as FAQs) and comments received on the proposed and interim rules.

## The Final Regulations

The final regulations are effective for plan years beginning on or after January 1, 2017, and provide some important clarifications that are summarized below.

### Grandfathered Plan Status

Certain group health plans and health insurance coverage that were in existence as of March 23, 2010, and remain largely unchanged are considered "grandfathered" health plans and are subject only to certain market reform provisions (for as long as they maintain grandfathered status). See our April 13, 2011 and November 2, 2010 issues of *For Your Information.*

Consistent with previous guidance, the new final rules also provide some clarifications:

- A group health plan's summary of benefits (SOB) must include a statement that it is grandfathered, and it must provide contact information for questions and complaints to maintain status as a grandfathered plan. Note that such a statement is required on the SOB, but is not necessary on every employee communication about the group health plan [e.g., not required on the explanation of benefits (EOB)].
- A group health plan or health insurance coverage must maintain those benefits offered under the plan as of March 23, 2010. The elimination of "all or substantially all" benefits to diagnose or treat a particular condition will cause a plan or health insurance coverage to lose its grandfathered status.

  **Comment.** The departments declined to establish a bright-line test indicating what constitutes "substantially all benefits." All facts and circumstances will be considered in the determination. The departments provided an example where a plan that previously (before March 23, 2010) provided benefits for a particular mental health condition, which combined counseling and prescription drugs, loses grandfathered status when it eliminates coverage for counseling.

- Contribution changes may not necessarily affect grandfathered status. A group health 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. Additionally, no corresponding changes in coverage terms that would otherwise cause the plan to cease to be a grandfathered plan are permissible.
- Adding an employer to a multiemployer plan may not affect grandfathered status. The addition of a 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, if the multiemployer plan has not made any other changes that would cause the plan to relinquish grandfathered status.
- The regulations maintain the concept that the grandfather rules apply separately to "each benefit package made available under a group health plan or health insurance coverage." So, a plan may lose its grandfathered status with respect to one of its benefit packages if certain changes are made, but keep its grandfathered status for other benefit packages.

  **Comment.** The regulations leave a few open issues including the effect that a wellness program premium incentive, such as a surcharge, might have on grandfathered plan status. While the departments addressed this issue in FAQs, the departments did not specifically address the issue in the final regulations.

Presumably, the departments' position expressed in the FAQ still stands. While wellness incentives are permitted and will not automatically cause a plan to lose grandfathered status, employers should carefully consider each component of their wellness program designs to be sure that modifying a component does not cause the plan to lose its grandfathered status inadvertently (e.g., making a change in the smoker surcharge that results in a greater than five percentage point reduction in the employer contribution rate). See our November 2, 2010 *For Your Information.*

## Preexisting Condition Exclusions

A group health plan and a health insurance issuer offering group or individual health insurance coverage generally may not impose any preexisting condition exclusions. The final rules are consistent with and incorporate the prior guidance. See our July 2, 2010 *For Your Information* for background information on the preexisting conditions exclusion requirements.

Note also that in 2014, final regulations amended existing HIPAA portability regulations, removing the requirement to provide certificates of creditable coverage. (See our April 2, 2014 *For Your Information.*)

## Lifetime and Annual Limits

Generally, group health plans and issuers are prohibited from imposing annual and lifetime dollar limits on "essential health benefits (EHBs)." Under the ACA, self-insured and large group health plans, are not required to offer EHBs, but if such coverage is provided under these plans, annual or lifetime dollar limits may not be imposed. (See our May 21, 2013 and November 11, 2010 issues of *For Your Information*.)

As in prior guidance, the final rule provides that:

- For purposes of determining what benefits would be considered EHBs (and subject to the annual and lifetime limit prohibition), self-funded and large group health plans (and grandfathered individual market plans) may define EHBs in a manner consistent with the three Federal Employees Health Benefit Program (FEHBP) or select among any of the 51 state-based benchmark plans identified by HHS, as applicable, for plan years beginning on or after January 1, 2017.
- Lifetime and annual dollar limits on EHBs are generally prohibited, regardless of whether the benefits are provided in-network or out-of-network.
- A health FSA offered through a cafeteria plan is not subject to annual limits.

## Account-Based Plans

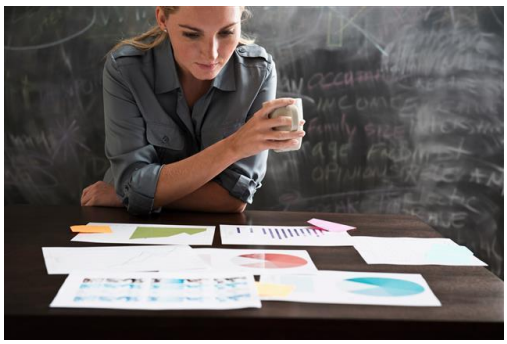
The lifetime and annual limit regulations define an "account-based plan" as an HRA, FSA or other group health plan that provides reimbursement of medical expenses (other than individual market policy premiums) with the reimbursement subject to a maximum fixed dollar amount for a period. This regulation incorporates prior IRS guidance limiting the circumstances under which an account-based plan may be offered to active employees without violating the lifetime and annual limit and preventive care regulations. See our August 24, 2015 *FYI In-Depth*, and April 7, 2015, July 8, 2014 and February 21, 2013 issues of *For Your Information.* The regulations include:

- **HRA integration.** The HRA "integration" rules set forth in earlier IRS guidance are incorporated into the regulations (see past publications noted above). An employer is required to, among other things, offer another group health plan that provides more than excepted benefits [e.g., a group health plan that provides comprehensive coverage (minimum value)] and that satisfies applicable ACA rules to HRA participants. The HRA participants, in turn, must be enrolled in a group health plan (either the one the employer sponsors or another) and must have an annual right to opt out of the HRA. If the group health plan the employer offers does not satisfy the ACA's "minimum value" requirements, then reimbursements from the HRA are limited to the payment of co-payments, co-insurance, deductibles and group health plan premiums and non-essential health benefits.
- **No individual premiums.** Except for retiree-only HRAs or HRAs that satisfy special Medicare or TRICARE integration rules, the regulations, like prior HRA guidance, do not allow an HRA to reimburse individual premiums, exchange premiums or Medicare supplement premiums. For a discussion on retiree HRAs, see our August 24, 2015 *FYI In-Depth*.

  **Comment.** The regulations allow HRA integration with Medicare for employers with fewer than 20 employees even if no group health plan coverage is offered to Medicare eligible individuals (i.e., because it is not required to be offered under the Medicare Secondary Payer rules). This guidance is more flexible than earlier guidance (Notice 2015-17), which required an employer to offer group health plan coverage to these individuals.

- **Account-based products.** The preamble to the regulations cryptically notes that the departments are aware of a variety of account-based products, "often with subtle but insubstantial differences," that circumvent the rules on the annual dollar limit prohibition and the preventive services requirement — and purport to be ACA compliant. The departments say they know these products are being marketed to the employer community and reiterate that the "subregulatory guidance not specifically addressed in these final regulations continues to apply and the Departments will continue to address additional situations as necessary."

  **Comment.** The departments could be referring to FAQs that discuss the situation where an employer does not establish a minimum value health insurance plan for its own employees, but provides cash payments or reimbursements of premiums that employees use to purchase health insurance (e.g., through a qualified health plan either in or outside the ACA marketplace). (See our July 8, 2014 *For Your Information.*) In the FAQs, the departments warn that employers could be subject to significant excise taxes if they reimburse employees' individual health insurance premiums either on a pre- or post-tax basis or if they offer employees with high claims risk a choice between the employer's health plan and cash. It's important for employers to be mindful of arrangements that promote account-based products and vet them with trusted advisors and counsel to ensure ACA compliance.



- **Suspended HRA.** The regulations allow an individual to suspend coverage under the HRA (rather than require permanent forfeiture), as long as the suspension is until a fixed date (or a participant's death, or the later of the two) and irrevocable until that date. For example, the regulations would permit a suspension for an entire plan year (e.g., January 1 through December 31). There does not appear to be a minimum suspension period. This rule is helpful for

early retirees who have access to a retiree HRA but would prefer to obtain marketplace coverage and qualify for the premium tax credit before becoming eligible for Medicare.

## Rescissions

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. (See our October 18, 2010 and July 2, 2010 issues of *For Your Information.*)

**Rescission Defined**

A "rescission" is a cancellation or discontinuance of coverage that has retroactive effect.

Although mostly consistent with previous guidance, the final rules include several clarifications:

- 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 the individual's decision or to retaliate against the individual.
- A retroactive cancellation or discontinuance of coverage initiated by the exchange is not a rescission.
- Rescissions are subject to internal claims and appeals and external review.
- A retroactive termination of coverage due to nonpayment of COBRA premiums is permissible.

> **Comment.** The departments don't define "material fact," but state that they might provide further guidance if additional questions arise. The preamble of the regulations addresses whether providing false or inaccurate information concerning tobacco use is considered a misrepresentation of material fact. The departments maintain their position that the remedy for false or inaccurate reporting of tobacco use is to recoup any additional premiums that should have been paid, not to rescind the coverage. The "remedy of recoupment renders any misrepresentation with regard to tobacco use no longer a 'material' fact for purposes of rescission," and coverage therefore cannot be rescinded on such basis. Until more definitive guidance or regulations are issued, employers wishing to rescind an individual's coverage should apply a reasonable, good faith standard to whether fraud or an intentional misrepresentation of material fact has occurred.

## Dependent Coverage

Group health plans and health insurance issuers offering group or individual health insurance coverage that covers children must make such coverage available for children until age 26. (See our February 25, 2011, January 25, 2011 and September 22, 2010 issues of *For Your Information.*) While generally consistent with previous guidance, the final rules include one key takeaway that could affect eligibility provisions in insured coverage, particularly HMO coverage:

- Adult children under age 26 must be offered coverage even if they do not live in a particular service area (but plans are not required to cover out-of-network services for these adult children). Thus any eligibility restrictions requiring adult children to live, work or reside in the service area will violate the final regulations. Plans and policies may need to be updated to bring them into compliance with this rule.

Examples in the regulations also illustrate the requirement that coverage of children under age 26 cannot vary based on age.

## Claims and Appeals (and External Review)

Group health plans and health insurance issuers must follow certain claims and appeals processes. The regulations finalize without substantial change the extensive rules on claims and appeal processes from existing guidance, but also incorporate a long list of clarifying technical guidance that includes the following:

- Free from charge, plans and issuers must provide the claimant with any new or additional evidence that the plan relied on or generated in connection with the appealed claim, as well as any new or additional rationale for the decision. Under the full and fair review rules, such information must be provided as soon as possible and in advance of the notice of final adverse benefit determination (with sufficient time for the individual to respond). The rules also clarify that this information must be provided automatically and merely giving notification of the availability of such information or rationale is not sufficient.
- The 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 National Association of Insurance Commissioners (NAIC) Uniform Model Act.
- 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 are considered adverse benefit determinations involving medical judgment. This means that such adverse benefit determinations may be subject to external review.

  **Comment.** This is a new requirement, specifically added to the list of claims subject to external review.

- The regulations discourage charging claimants a filing fee for an appeal, but indicate that an external review process with a nominal filing fee that does not exceed $25 is permitted. It must be waived, however, if it would cause hardship.

**A Lot's Been Written About This**

For more on the claims and appeals process, refer to these issues of *For Your Information:*

**July 7, 2015**

**August 4, 2011**

**October 1, 2010**

**September 1, 2010**

**August 11, 2010**

**April 12, 2010**

Concurrent with these final regulations, the DOL issued proposed regulations that follow the procedures for health care claims and appeals, but are applied towards adjudicating claims for benefits conditioned on a determination of disability, including claims for disability retirement benefits. (See our December 15, 2015 *For Your Information.*)

## Patient Protections

Group health plans and health insurance issuers must abide by certain rules regarding primary care provider designation and coverage for emergency services for non-grandfathered group health plans. (See our July 2, 2010 *For Your Information.*) The final rules provide some clarifications:

- Classification of a primary care provider is determined based on the plan or policy terms and in accordance with applicable state law. There is no standard definition.

- If a plan or issuer requires the designation of a participating primary care provider (PCP) 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 PCP.
- All women, regardless of age, must be ensured direct access to OB/GYN care.
- Plans and issuers may apply reasonable and appropriate geographic limitations on which participating PCPs are considered available to be designated as such.
- Emergency care is not limited to treatment within 24 hours of the onset of an emergency. A plan or issuer must provide coverage for emergency services, without any time limit within which treatment must be sought.

## Effective Date

The rules apply 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 and will supersede all existing guidance. For calendar year plans (or policy years in the case of an insured plan), this means January 1, 2017.

## In Closing

These final regulations include some important clarifications on the market reform rules. It's time now for employers, insurers, TPAs and vendors to consider the nuances and changes made by these final rules and determine what modifications, communications and other changes are needed to bring the plan(s) into compliance.

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