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Regulations Address Mandated Benefits

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On November 18, 2015, the Departments of Treasury, Labor, and Health and Human Services ("Departments") issued final regulations regarding certain mandated benefits under the Affordable Care Act ("ACA"). The regulations largely incorporate various FAQs and remove outdated provisions (e.g., annual limitations on essential health benefits, now phased out). However, there are a few items worthy of note.

Lifetime and Annual Limits

Background: There can be no lifetime or annual dollar limits on "essential health benefits" ("EHBs").

Rules: The regulations provide that:

- a reasonable interpretation of EHBs for self-funded plans includes choosing from among any of the 51 EHB base-benchmark plans; and

- 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.

Health Reimbursement Arrangements

Background: Health reimbursement arrangements ("HRAs"), in part, must allow the employee (or former employee) to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

Rule: 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).

Account-based Products

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.

Rescissions

Background: A group health plan must not rescind coverage under the plan with respect to an individual once the individual is covered under the plan, unless the individual performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Rules: The regulations state:

- that a retroactive cancellation 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;
- that rescissions are subject to internal claims and appeals and external review; and
- with respect to an individual who is found to have reported false or inaccurate information about their tobacco use, the individual may be charged the appropriate premium that should have been paid retroactive to the beginning of the plan year; however, coverage cannot be rescinded on such basis.

Dependent Coverage

Background: Any group health plan or health insurance carrier that provides coverage of dependent children must continue to make dependent coverage available until the children turn 26 years of age. There is no definition of dependent. A previously-issued FAQ indicated that a plan can limit eligible children to the following:

- natural children;
- children adopted or placed for adoption;
- stepchildren; and
- eligible foster children (individuals placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction).

It has been unclear whether this is a minimum required definition, safe harbor, or example.

Rule: The regulations incorporate the FAQ without further clarification so the answer remains unclear.

In addition, the rule indicates that 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.

Grandfathered Plans

Background: Grandfathered status is lost when, among other things, the employer or employee organization decreases its contribution rate based on cost of coverage towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the contribution rate for the coverage period that includes March 23, 2010.

There was some question as to what percentage increase could be allowed when the employee contribution was $0 on March 23, 2010. While 5% of $0 = $0, should there be allowed some small increase?

Rule: The Departments confirmed that no increase is allowed.

The Departments also confirmed that once grandfathered status is lost, there is no opportunity to cure the loss of grandfather status; a reversal of a change that causes the loss of grandfathered status (e.g., an elimination of benefits) after the effective date will not allow the plan to regain grandfather status.

Patient Protections

Background: If a non-grandfathered group health plan requires or provides for designation by a participant or beneficiary of an in-network primary care provider, then the plan must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary.

Rule: 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.

Emergency Care

Background: Non-grandfathered plans must cover emergency services without prior authorization and even if out-of-network.

Rule: 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. For example, emergency care is not limited to treatment within 24 hours of the onset of an emergency.

Claims and Appeals

Background: A non-grandfathered group health plan and a health insurance carrier must implement an effective appeals process for appeals of coverage determinations and claims under which the plan or carrier must:

- have in effect an internal claims appeal process;
- allow an enrollee to review his file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and
- provide an external review process for such plans and carriers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners ("NAIC") and is binding on such plans.

Rules:

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. 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.

5. 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 is subject to the claims and appeals procedures.

6. 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, which generally require, among other things, parity in the application of medical management techniques, is subject to the claims and appeals procedures.