



WHAT EMPLOYERS NEED TO KNOW RIGHT NOW ABOUT HEALTH CARE REFORM

Agencies Issue Final Rule on Grandfathered Health Plans and Other Initiatives

On November 13, 2015, federal agencies issued a [final rule](#) that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of Patient Protection and Affordable Care Act (ACA) initiatives such as grandfathered health plans, preexisting condition exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

The final rule also noted that various transitional rules are now void, such as the allowance of grandfathered health plans to exclude children under age 26 who were eligible for other group health plan coverage, and rules that provided a special enrollment period for children under age 26 who had been excluded from coverage.

Grandfathered Health Plans

The final rule reaffirmed that grandfathered status applies separately with respect to each benefit package. For example a group health plan with a preferred provider organization (PPO) plan, a point of service (POS) arrangement, and a health maintenance organization (HMO) option would each carry grandfathered status (or not) separately. Requirements for grandfathered status notification remain the same – plans must include a statement that the plan or health insurance coverage believes it is a grandfathered health plan in any summary of benefits provided under the plan. The model disclosure notice remains the same.

Grandfathered plans have been governed by anti-abuse rules, to prevent plans from maintaining grandfathered status when employees transferred into the plan are from a transferee plan that would have caused the transferor plan to lose grandfathered status if its terms were adopted. There is an exception for bona fide reasons for employee transfers, such as a plan being eliminated by the carrier.

The final rule noted that a plan that eliminated substantially all benefits needed to diagnose a condition would cause a plan to lose its grandfathered status, but purposefully declined to provide a bright line rule to interpret the requirement. Excessive increases to a single or limited number of copayments would cause a plan to lose grandfathered status, even if the remaining copayments remained the same.

Plans that add additional tiers (such as individual plus one, individual plus two) will not lose grandfathered status if the contribution rate for the new tiers is not below the previous non-self-only tier by more than five percent. Employers with grandfathered health plans that offer wellness programs should take great caution if the wellness program imposes penalties for failing to meet standards, this could put the plan's grandfathered status at risk. Finally, grandfathered health plans may move brand-name versions of drugs that become generic to a higher cost-sharing tier.

Preexisting Conditions

The final rule clarifies that a carrier can bar coverage for a specific condition if it does so regardless of when the condition arose. Caution should be exercised to take other requirements into account, such as essential health benefit requirements.

Lifetime and Annual Coverage Limits

Carriers and group health plans are prohibited from imposing lifetime and annual limits on coverage. Because health reimbursement arrangements (HRAs) cannot meet this requirement and are a group health plan, HRAs must be integrated with a group health plan in order to meet the requirements of the ACA. HRAs are still prohibited from being used to purchase individual plan premiums.

There are two sets of requirements for HRA and other account-based plan integration. An HRA that does not need to meet minimum value requirements is considered integrated if:

- A. The plan sponsor offers a group health plan (other than the HRA or other account-based plan) to the employee that does not consist solely of excepted benefits;
- B. The employee receiving the HRA or other account-based plan is actually enrolled in a group health plan (other than the HRA or other account-based plan) that does not consist solely of excepted benefits, regardless of whether the plan is offered by the same plan sponsor (referred to as non-HRA group coverage);
- C. The HRA or other account-based plan is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the non-HRA group coverage is offered by the plan sponsor of the HRA or other account-based plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA group coverage, such as a group health plan maintained by the employer of the employee's spouse);
- D. The benefits under the HRA or other account-based plan are limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care that does not constitute essential health benefits; and
- E. Under the terms of the HRA or other account-based plan, an employee or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually and, upon termination of employment, either the remaining amounts in the HRA or other account-based plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan.

An HRA or other account-based plan will meet integration requirements and minimum value if:

- A. The plan sponsor offers a group health plan (other than the HRA or other account-based plan) to the employee that provides minimum value pursuant to IRS Code (and its implementing regulations and applicable guidance);

- B. The employee receiving the HRA or other account-based plan is actually enrolled in a group health plan that provides minimum value pursuant to IRS Code (and applicable guidance), regardless of whether the plan is offered by the plan sponsor of the HRA or other account-based plan (referred to as non-HRA MV group coverage);
- C. The HRA or other account-based plan is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the non-HRA MV group coverage is offered by the plan sponsor of the HRA or other account-based plan (for example, the HRA may be offered only to employees who do not enroll in an employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a group health plan maintained by an employer of the employee's spouse); and
- D. Under the terms of the HRA or other account-based plan, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan at least annually, and, upon termination of employment, either the remaining amounts in the HRA or other account-based plan are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA or other account-based plan.

Rescissions

Rescissions of coverage, or cancelling coverage retroactively or with a retroactive effect, have been prohibited since 2010, unless there is fraud or misrepresentation of material fact. The final rule did not provide a definition of "material fact."

The rescission rules do not apply when an employee fails to or delays informing its employer that he or she has divorced a covered spouse, or a COBRA-qualified beneficiary fails to pay for COBRA coverage.

Rescissions are subject to internal and external appeal. Coverage must remain effective until an internal appeal is completed, and enrollees must be given 30 days notice prior to rescission to allow them time to appeal.

Adult Children

Group health plans and carriers must cover all children up to age 26, regardless of financial dependency or shared residence, student status of the child, employment status, or marital status. They must also be covered even though they do not live in a plan's service area. Plans are not required, however, to cover out-of-network services for adult children, and the rule does not extend to grandchildren or other relatives.

Appeals

The final rule finalized additional requirements for internal appeals for individual plans. The final rule clarified that non-grandfathered fully insured group health plans and individual insurers must comply with the state's external review processes if the state process offers the same consumer protections offered by the National Association of Insurance Commissioner's Uniform Health Carrier External Review Model Act. Self-insured plans and insurers in states without this requirement must use a process that meets the Department of Health and Human Services (HHS) standards, which were narrowed in regard to adverse benefit determinations. Originally all final adverse benefit determinations were permitted to be reviewed. The final rule determined that only final review of adverse benefit decisions involving medical judgment and rescission may be reviewed. Examples of medical judgment claims were provided. Coding decisions may involve medical judgment and are appealable.

The final rule also provided the federal review process rules which were previously found in guidance. Group health plans have five days to complete a review of an appeal to determine if it is eligible for an external review, and then assign the appeal to an accredited independent review organization. That organization, or IRO, notifies the claimant, who has 10 days to provide additional information. Decisions must be issued, in writing, within 45 days, unless the situation involves serious jeopardy to life or health, in which case decisions must be made within 72 hours. Group health plans must contract with three accredited IROs and assign them claims through unbiased means.

The regulations discourage filing fees for claimants, but in states that are required to charge a filing fee, it must not exceed \$25, and must be waived if it would cause hardship.

Designation of a Primary Care Provider

Plans that require or provide for designation of a primary care provider must allow the participant (or beneficiary or enrollee) to designate any available in-network primary care provider. Women do not need authorization for care from an obstetrician or gynecologist, who must be treated as primary care providers for purposes of ordering and authorizing services.

Similarly, plans that require the designation of a participating primary care provider for a child must permit the designation of a physician who specializes in pediatrics if they are in-network.

Access to Emergency Care

Plans and carriers may not impose administrative hurdles or requirements to limit access to emergency care, or charge additional copayments or coinsurance for out-of-network emergency care. Out-of-network emergency providers may balance bill, and plans or carriers are not required to pay a balance bill. Plans and carriers must pay a reasonable amount for out-of-network emergency care, which is:

1. The median amount it pays for in-network-providers;
2. The amount it usually pays out-of-network providers; or
3. The Medicare rate.

Federal agencies indicated they might prohibit balance billing in the future.

11/23/2015

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