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Health Care Reform ("PPACA") Legal Developments
2015 Year-End Update

1. In November 2015, the IRS, HHS, and DOL (the "Agencies") published **final regulations on many PPACA benefit mandates**, including the rules regarding grandfathered health plans, preexisting condition exclusions, lifetime and annual dollar limits, rescissions, coverage of adult dependent children, claims and appeal procedures, and patient protections. The final regulations are effective for plan years beginning in 2017 or later, and will replace prior regulations issued in 2010. The final regulations break little new ground—they incorporate much of the PPACA FAQ guidance that the Agencies issued on these provisions since 2010, but otherwise adopt the prior regulations without substantial change.

2. The Cadillac tax is a 40% excise tax on high-cost employer-provided health coverage. Originally, the tax was scheduled to take effect in 2018 and would have been non-deductible by the employer. However, in December 2015 a new law was passed that **delays the Cadillac tax for two years** (to 2020) and allows employers to deduct the tax. Even so, there have been bipartisan efforts to repeal or reduce the Cadillac tax and we anticipate those efforts will continue.

3. In June 2015 the U.S. Supreme Court decided the *King v. Burwell* case, in which the plaintiffs used a literal reading of PPACA to argue that the government may only **subsidize health coverage** that is purchased on a state-based Exchange.[1] The Court rejected this argument, reasoning that Congress intended to treat the state and federal Exchanges the same for purposes of coverage subsidies. The case received much publicity because its outcome impacted PPACA's survival—had the Court sided with plaintiffs, many lower-income individuals would have lost access to subsidized Exchange coverage.

4. Under PPACA, non-grandfathered plans must provide in-network **preventive care benefits** without cost-sharing. This requirement continued to receive considerable attention in 2015, including the following guidance:

   - Agency FAQs clarifying that preventive care must include at least one form of contraception in each of 18 categories. Plans may use "reasonable medical management techniques" to encourage the use of certain contraceptives within a particular category—for example, plans could limit coverage of birth control pills to generics only.[2] The Agencies also confirmed that the rules for preventive care contraceptives

[1] *King v. Burwell*, 135 S. Ct. 2480 (2015).

[2] However, plans must make an exception if a covered person's health care provider determines that a particular contraceptive is medically necessary for that person.

apply to all females of child-bearing age who are covered by the plan, including dependent children.

- Agency FAQs clarifying the coverage that must be provided for preventive care genetic counseling and BRCA genetic testing, colonoscopies, mammograms and other sex-specific services, behavioral interventions for adult obesity, and lactation support services.
- Final preventive care regulations consolidating previously issued guidance, and providing that plans generally may not stop covering a preventive care service mid-year even if the service no longer qualifies as preventive care under the law.
- The U.S. Preventive Services Task Force added several new and/or updated preventive care recommendations: (1) high blood pressure screening; (2) abnormal blood glucose and diabetes type 2 screening; and (3) tobacco use counseling (plus interventions, for non-pregnant adults).[3]

5. Under PPACA, plans cannot impose dollar limits on essential health benefits ("EHB"). In general, a self-funded plan's EHB are those benefits covered by its chosen state's benchmark plan (any state's benchmark plan may be chosen for this purpose). The current benchmark plan options apply through the plan year beginning in 2016, and CMS recently announced the **new EHB benchmark plan options** that will apply after that.[4] As a state's new benchmark plan may differ from its current benchmark, self-funded plans should reevaluate their choice of benchmark plan before 2017.

6. For 2016, **out-of-pocket maximums** on in-network benefits cannot exceed $6,850 for self-only coverage and $13,700 for family coverage.[5] The Agencies have interpreted the "self-only" maximum as a "per person" maximum, effective for plan years beginning in 2016 or later. In other words, for any individual covered by the plan, that individual's out-of-pocket costs cannot exceed the self-only maximum—and if the individual has family coverage, the family's out-of-pocket costs cannot exceed the family coverage maximum.

7. Enrollment counts for the 2015 **transitional reinsurance ("TR") contribution** were due by November 16, 2015. The first installment of the 2015 fee is due by January 15, 2016. The TR contribution is $44 per covered life for 2015 and $27 per covered life for 2016 (the last year for which the TR contribution is owed). Self-funded health plans are exempted from the 2015 and 2016 contributions if they do not use a third-party administrator for certain administrative functions like enrollment and claims processing.

[3] Details about the new preventive care recommendations can be found on the USPSTF's website, at www.uspreventiveservicestaskforce.org. The Agencies also intend to keep the list of preventive care services at https://www.healthcare.gov/preventive-care-benefits updated for any changes.

[4] The list of new benchmark plans is available at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

[5] HSAs and high-deductible health plans are also subject to out-of-pocket limits under Code § 223. For 2016, these limits are $6,550 for self-only coverage and $13,100 for family coverage.

8. The **Patient Centered Outcomes Research Institute ("PCORI") fee** increased to $2.17 per covered life for the plan year ending after September 30, 2015 and before October 1, 2016. The next PCORI fee must be paid by July 31, 2016.

9. The deadline to implement the **ICD-10** (the World Health Organization's set of diagnostic and medical procedure codes) was October 1, 2015.

10. PPACA requires that health plans obtain two certifications of compliance with the **HIPAA electronic transactions rules**. In January 2014, HHS issued proposed regulations on the first HIPAA certification. If the proposed regulations had been finalized without change, health plans generally would have needed to submit the first certification to HHS by the end of 2015. However, HHS has not yet issued final regulations. According to HHS' website, it is still analyzing comments received on the proposed regulations.

11. PPACA requires that Exchanges notify employers if an employee enrolls in **Exchange coverage and qualifies for a subsidy** (this can happen if the employee attests that he/she is not enrolled in employer-provided coverage and was not offered affordable, minimum value employer coverage). The federal Exchange will start providing the notice beginning in 2016 (many state-based Exchanges have already been doing so). Employers that receive a notice should evaluate whether the employee may have received the subsidy in error and, if so, consider filing an appeal, both to protect against potential "play or pay" penalties and to prevent the employee from possible tax penalties for wrongfully receiving a subsidy.

12. In December 2015, the IRS released final regulations on determining whether an employer provides **affordable, minimum value coverage**, including rules on how wellness program rewards, employer HRA contributions, and employer cafeteria plan contributions are taken into account. The regulations also clarify that a former employee will not lose eligibility for subsidized Exchange coverage merely because he or she is offered (but does not enroll in) affordable, minimum value COBRA or retiree coverage.

13. The IRS has issued forms (and instructions) that health plans and insurers must use to annually **report "minimum essential coverage"** to the IRS and enrollees and that "applicable large employers" must use to report information related to their compliance with the "play or pay" requirements (Forms 1094-B, 1095-B, 1094-C and 1095-C). The instructions clarify which forms to use and how to complete them, and provide guidance on reporting HRA coverage, offers of COBRA coverage, and multiemployer plan coverage. Reporting is first required in 2016 (for 2015 coverage) and the IRS has **extended the due dates** for these first filings.[6]

14. PPACA originally required that certain large employers automatically enroll new full-time employees into the employer's health plan. In 2012, the Agencies advised that employers did not have to comply until final regulations were issued (which did not occur). In

[6] The deadline to furnish 2015 forms to employees was extended from February 1 to March 31, 2016, and the deadline to file with the IRS was extended from March 31 to May 31, 2016 (or June 30, 2016, if filed electronically).

November 2015, following lobbying efforts by business groups and bipartisan support in Congress, President Obama signed legislation that **repealed PPACA's automatic enrollment rule**.

15. In June 2015, the Agencies published amended final regulations on the **summary of benefits and coverage ("SBC")** requirement. The regulations incorporate prior FAQ guidance and provide instruction for insured plans on SBC timing and content. The Agencies expect to issue additional SBC guidance in January 2016, including updated model SBC documents.

16. PPACA prevents plans from **discriminating against health care providers** who are acting within the scope of their license. In 2013 FAQs, the Agencies advised that this rule does not require that plans accept all types of providers into their networks, or prevent plans from varying provider reimbursement rates based on market considerations. The Senate Appropriations Committee objected, claiming that the Agencies were permitting the type of discrimination that PPACA was intended to prevent. In May 2015 the Agencies rescinded their prior FAQs and announced that they will not take enforcement action against any plan that complies with a reasonable, good-faith interpretation of the nondiscrimination rule until further guidance is issued.

17. **"Excepted benefits"** are generally exempt from PPACA's benefit mandates and HIPAA portability requirements. One type of excepted benefit is insurance coverage that supplements group health coverage and is similar to Medicare or TriCare supplemental coverage. In February 2015, the Agencies stated that they intend to propose additional regulations on this type of excepted benefit. In the meantime, the Agencies will treat supplemental coverage as an excepted benefit so long as it meets specified requirements.

18. In December 2015, the IRS issued guidance on a wide range of PPACA and non-PPACA provisions, including: (1) how the employer "play or pay" excise taxes apply to governmental entities; (2) the Code § 6056 information reporting requirements for applicable large employers; (3) how the Code's HSA rules apply to veterans; (4) the interaction between COBRA and the health FSA carryover rules; and (5) how PPACA's market reforms apply to HRAs and other account-based plans, and restrictions on the ability to use such plans to pay for individual coverage.

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