

ACA CHANGES INCORPORATED INTO ERISA

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. Amendments to the Affordable Care Act made through the Health Care Education and Reconciliation Act (Reconciliation Act) were signed into law on March 30, 2010, and some additional amendments have been made since that date, notably the Protecting Affordable Coverage for Employees Act (PACE Act),¹ enacted in 2015, which restored the pre-ACA upper limit of 50 employees for “small employer” status, unless a state chooses to raise its threshold to 100 employees. Generally, the ACA’s market reform provisions amend title XXVII of the Public Health Service Act (PHS Act), which is administered by the Department of Health and Human Services. The Affordable Care Act also adds a new section 715 to ERISA, administered by the Department of Labor, Employee Benefits Security Administration, and a new section 9815 to the Internal Revenue Code (IRC), administered by the Department of Treasury, Internal Revenue Service (IRS). These sections incorporate most of the market reform provisions of the PHS Act into ERISA and the IRC, and make them applicable to group health plans and health insurance issuers providing group health insurance coverage.

The PHS Act sections incorporated by this reference are sections 2701 through 2728, except that 2718 (minimum medical loss ratio) do not apply to self-insured ERISA plans, nor do any provisions that apply only to health insurance issuers, such as guaranteed issue and community rating. PHS Act sections 2701 through 2719A incorporate, in revised form, the basic portability framework originally enacted by HIPAA, and add many new protections. PHS Act sections 2722 through 2728 are sections of prior law renumbered with some, mostly minor, changes. Thus, all these ACA provisions now apply to both insured and self-insured health benefit plans, with one noteworthy exception. Certain plans existing on the date of enactment of the ACA, March 23, 2010, are designated as “grandfathered plans” and are exempt from many of the new provisions of the PHS Act if they remain in force without material changes.² In addition, these provisions do not apply to retiree-only or excepted benefits plans (See ERISA Section 732). The USDOL, HHS, and the Treasury have been issuing guidance and regulations on an ongoing basis since May 2010.

In the ACA, the term “group health plan” includes both insured and self-insured group health plans. The term “health plan” as used in the ACA does not include “self-insured group health plans.” Subtitles A and C of title I of the ACA amend the requirements of title XXVII of the PHS Act (changes to which are incorporated into ERISA section 715). The preemption provisions of

¹ Pub. Law 114-60.

² ACA § 1251 (42 U.S.C. § 18011), as modified by ACA § 10103 of the ACA and Reconciliation Act § 2301. The specific provisions that apply to grandfathered plans depend on whether the plan is an individual or group plan, and whether it is insured or self-insured. Through administrative guidance, CMS has also allowed insurers, if permitted by state law, to keep existing insurance policies (popularly known as “transitional” policies) in force through the end of 2017 without complying with certain ACA requirements that took effect on January 1, 2014.

ERISA section 731 and PHS section 2724 (implemented in 29 CFR 2590.731 (a), 45 CFR 146.143 (a) and IRC section 9815) apply so that the requirements of the ACA are not to be “construed to supersede any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent such standard or requirement prevents the application of a requirement” of the ACA. Accordingly, state laws that exceed the ACA’s minimum standards for health insurance issuers will generally not be superseded by the ACA. However, ERISA preemption prohibits states from imposing their own minimum standards on self-insured ERISA plans.

The HHS, USDOL and the Treasury (the “Departments”) issued a series of regulations in phases implementing PHS Act sections 2701 through 2719A, some of which became effective on September 23, 2010, six months after the effective date of the ACA. Those regulations contained what is referred to as the “immediate market reforms,” which are discussed in more detail below. The immediate market reforms include: coverage for adult children up to age 26 (PHS 2714), \$0 preventive care (PHS 2713), no lifetime limits, phased in elimination of the “no annual limit” requirement (PHS 2711), no pre-existing condition exclusions for children under the age of 19 (PHS 2704), and limits on rescissions of coverage (PHS 2712). Some of these reforms applied only to non- grandfathered health plans. Other reforms apply to both grandfathered and non-grandfathered. Therefore, it was also necessary for the “immediate reform” regulations to include regulations defining the types of changes to an insurance policy or self-insured plan that would trigger the loss of grandfathered status. Many more regulations have been issued since that time. For instance, in 2014, the immediate reforms were extended by eliminating pre-existing condition exclusions for all enrollees, regardless of their age, and annual dollar limits were eliminated entirely for all healthcare services that are considered “essential health benefits.”³

Because subtitles A and C of title I of the Affordable Care Act contain requirements that are applicable to both the group and individual market health insurance markets, a new part 147 in subchapter B of 45 CFR was added to implement the provisions of the ACA. The provisions of the ACA, to the extent that they also apply to group health plans (including self-funded) and to group health insurance coverage issued in connection with a group health plan, are also implemented under new regulations added to 29 CFR part 2590 and 26 CFR part 54.⁴

Incorporating these new sections into ERISA is significant because for the first time a comprehensive structure of benefit mandates was added to ERISA requirements. Although HIPAA had added a few provisions to ERISA and the IRC that echoed similar language in the

³ This includes plans that are exempt from the requirement to provide all essential health benefits. Therefore, large group insurers and self-insured employers must adopt a reasonable definition of essential health benefits that is generally consistent with the approach applied in the individual and small group insurance markets. 45 CFR § 147.126(c) (HHS); 29 CFR § 2590.715-2711(c) (DOL); 26 CFR § 54.9815-2711(c) (IRS).

⁴ The bulk of this information was taken from the preamble to the federal regulations issued 5/13/10

PHS Act, notably the limitations on pre-existing condition exclusions,⁵ those had been the exception rather than the rule. Traditionally, ERISA did not dictate to employers what benefits and protections had to be contained in employer health plans. A good example of this is the Mental Health Parity and Addiction Equity Act of 2008, which provides: IF the employer offers any mental health benefits, then those benefits must meet the requirement of full parity with physical health benefits generally. Another example is the Newborns' and Mothers' Health Protection Act: IF the health plan covers maternity benefits, it has to include the "minimum stay" requirements.

By contrast, the ACA is largely mandatory in nature. Because substantial parts of the ACA have been incorporated into ERISA, the nature of ERISA has been changed. In addition, even though the ACA preserves the employer's right to decide whether to offer a health plan at all, the ACA includes an employer "shared responsibility" provision, sometimes called "play or pay," that gives large employers (50 or more fulltime or fulltime equivalent employees)⁶ a strong incentive to provide "affordable" health plans to employees and their child dependents.⁷ Although this law is sometimes referred to as the large employer "mandate," it does not literally mandate that employers offer such plans. However, even though employers that choose not to do so are not deemed to be in violation of any ACA requirement, they may be subject to substantial financial penalties under the ACA's employer "shared responsibility" provisions. Small employers, under 50, are not subject to the penalties associated with shared responsibility.⁸

Specifically, if an employer subject to shared responsibility fails to offer a group health plan that qualifies as "minimum essential coverage" under the ACA (*i.e.*, provides more than "excepted benefits"), or if participating employees are eligible for subsidized coverage on the Exchange because the employer's plan fails to meet the "affordability" test or fails to provide a minimum actuarial value of 60%, then, in each month when at least one full-time employee receives premium tax credits, the employer must make a payment to the IRS of either: (a) \$2000 per year (prorated monthly) for every full-time employee over 30,⁹ if the employer does not offer minimum essential coverage at all; or (b) the lesser of that amount or \$3000 per year (prorated monthly) for every full-time employee receiving subsidized coverage, if the employer offers minimum essential coverage that is not affordable or does not provide minimum value.¹⁰

⁵ See ERISA § 701 (29 U.S.C. § 1181); IRC § 9801 (26 U.S.C. § 9801); *former text of PHS Act* § 2701 (42 U.S.C. 300gg).

⁶ Note that an employer with exactly 50 employees, all working fulltime, is considered "small" for purposes of the small group insurance laws but "large" for the purposes of the shared responsibility law.

⁷ IRC § 4980H (26 U.S.C. § 4980H), *added by* ACA § 1513.

⁸ The ACA does provide a two-year tax credit as an incentive for certain small employers to establish health plans. IRC § 45R (26 U.S.C. § 45R), *added by* ACA § 1421.

⁹ Although employer size is calculated on the basis of the number of "full-time equivalent" employees, only employees actually working at least 30 hours a week are counted when calculating the penalty. IRC § 4980H(c)(2)(E) (26 U.S.C. § 4980H(c)(2)(E))

¹⁰ IRC § 4980H (26 U.S.C. § 4980H); IRC § 36B(c)(2)(C) (26 U.S.C. § 36B(c)(2)(C)), *added by* ACA § 1401; IRC §§ 5000A(f)(2) & (3) (26 U.S.C. §§ 5000A(f)(2) & (3)), *added by* ACA § 1501.

This limits the impact of a major distinction between the ACA’s requirements for individual and small group insurance and the ACA’s requirements for large group insurance and self-funded benefit plans. Individual and small group insurance policies must include all essential health benefits and (with the exception of the catastrophic individual plan) must provide at least a “bronze” level of coverage (60% actuarial value), but large employers (and self-funded small employers) are not subject to those requirements.¹¹ However, even though large employer health plans do not have to include all 10 categories of “essential benefits,”¹² the “minimum value” calculator used by the Treasury to calculate the value of a group health plan does factor in the extent to which certain EHB categories are covered. If major categories, such as prescription drugs, maternity or mental health, are left out of the plan, the plan may not meet the minimum actuarial value of 60% and therefore could subject the employer to “shared responsibility” penalties. In addition, all health plans, including self-funded ERISA plans, are subject to a maximum “in-network” out-of-pocket limit that is adjusted annually for inflation by CMS (in 2016 set at \$6850 individual/\$13,700 family).

The large employer “shared responsibility” provisions of the ACA can have significant financial impacts on large employers that previously did not offer coverage to all of their employees who work at least 30 hours a week, or that offered coverage that did not meet MEC, affordability or minimum value requirements. There is speculation that the ACA will have even broader impacts. For instance, the “play or pay” employer mandate only requires health plan coverage for employees who work 30 hours or more a week. This creates incentives for employers to limit or reduce hours for their employees. Some ERISA experts argue that if employers use that strategy to limit their costs, they may be exposing themselves to an action under ERISA Section 510, which makes it unlawful for a person to interfere with the attainment of any right a participant may become entitled to under a plan. Another strategy to avoid the penalty and/or the cost of offering “real” coverage is to offer minimal coverage that still meets MEC, such as coverage consisting of outpatient preventive services only, and then “gamble” on the proposition that few employees will actually sign up for individual coverage with a tax credit. Additionally, an employee who enrolls in Medicaid, rather than in subsidized insurance through the Exchange, does not trigger the penalty for failing to offer MEC and is not counted in calculating the penalty for failing to offer affordable coverage with minimum value. This discussion is beyond the scope of this handbook, but it is interesting to note here.

The following discussion of the significant reforms added to ERISA by the ACA is based largely on the USDOL compliance checklist. See EBSA’s Website: <http://www.dol.gov/ebsa/healthreform/> for the most up-to-date USDOL guidance.

¹¹ PHS Act § 2707(a) (42 U.S.C. § 300gg-6(a)).

¹² The ten essential benefit categories are: outpatient services, emergency services, hospitalization, maternity and newborn care, mental health/substance abuse disorder services, prescription drugs, rehabilitative/habilitative services and devices, laboratory services, preventive benefits and chronic disease management, and pediatric services, including dental and vision. ACA § 1302(b)(1) (42 U.S.C. § 18022(b)(1)).

Significant Reforms

1. Grandfathered status – (29 CFR 2590.715-1251(f))

The grandfathered status of a plan will affect whether a plan must comply with certain provisions of the Affordable Care Act (ACA). Grandfathered status is intended to allow people to keep their coverage as it existed on March 23, 2010, while giving plans some flexibility to make “normal” changes while retaining grandfathered status. Restrictions and requirements on grandfathered health plan coverage provide individuals protection from significant reductions in coverage, provide for coverage to include numerous protections implemented through the Affordable Care Act, and allow employers the flexibility to manage costs.

2. Wellness Program Provisions – (29 CFR 2590.702 and 29 CFR 2590.715 – 2705)

Wellness programs are programs of health promotion or disease prevention, and they must comply with the final wellness program regulations, which use joint authority under HIPAA and the ACA. A wide range of wellness programs are permitted, but the regulations generally prohibit discrimination based on health factors, with exceptions for benign discrimination (*e.g.*, making benefits specifically available to persons with designated health conditions) and participation incentives (provided that outcome-based incentives must make reasonable alternatives available if necessary for all participants to have a reasonable opportunity to earn the incentive).

3. MHPAEA – (29 CFR 2590.712)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

Employer plans do not have to follow the provisions of MHPAEA if they do not offer ANY mental health benefits. This is relevant primarily to self-funded plans, because most fully insured plans are required to provide these benefits by state or federal law. Most states require some form of mental health benefits for large group health insurance, and those state mandated benefits would trigger the application of MHPAEA in fully insured group health plans. Fully insured small employer groups are required to comply with MHPAEA because mental health and substance abuse treatment benefits are part of the required essential health benefit package.

In addition to requiring full parity with physical health for financial requirements and quantitative treatment limitations, there are also regulations limiting non-quantity treatment

limitations, which are actions taken by an insurer to discourage claims, such as excessive pre-authorization requirements.

4. Dependent Coverage of Children to Age 26 – (29 CFR 2590.715-2714)

Applicable only to group health plans that provide coverage for dependent children. Group health plans and issuers cannot deny or restrict dependent coverage for a child who is under age 26 as long as the relationship between a child and the participant entitles the child to coverage under the terms of the plan. Thus, plans cannot deny or restrict dependent coverage for a child who is under age 26 based on the presence or absence of financial dependency upon or residency with the participant or any other person, student status, employment or any combination of these factors. In addition, plans and issuers cannot limit dependent coverage based on whether the child under age 26 is married. The terms of the plan cannot vary based on age, except for children who are age 26 or older. This provision applies to both grandfathered and non-grandfathered plans.

Note that beginning in January 2015, if a large employer fails to offer coverage to employee's children up to age 26, it may be subject to a penalty under the regulations governing employer shared responsibility payments.

5. Rescission Provisions – (29 CFR 2590.715-2712(a)(2))

A group health plan must not rescind coverage with respect to an individual (including a group to which the individual belongs, or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

6. Prohibition on Lifetime and Annual Dollar Limits on EHB – (29 CFR 2590.715-2711(a)(1))

A group health plan may not establish any annual or lifetime limits on the dollar amount of benefits for any “essential health benefit” for any individual. This applies to both grandfathered and non-grandfathered plans. Plans that are not subject to the requirement to provide all essential health benefits must define “essential health benefits” consistent with a reasonable interpretation of the term. *See Preamble to Interim Final Regulations, at 75 Federal Register 37188 37191.*

7. Prohibition on Pre-existing Condition Exclusions – (29 CFR 2590.701-2)

For plan years beginning on or after January 1, 2014, group health plans may not impose pre-existing condition exclusions. The definition of a pre-existing condition exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a

result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of denial), such as a condition identified as a result of a pre-enrollment questionnaire or a physical examination given to the individual, or a review of medical records relating to a pre-enrollment period. This provision applies to both grandfathered and non-grandfathered plans.

This is considered an immediate market reform, but from 9/23/10 until 12/31/13 the provision was only applicable to children less than age 19.

8. 90-day Waiting Period – (29 CFR 2590.715-2708)

PHS Act section 2708, as added by the Affordable Care Act and incorporated into section 715 of ERISA, prohibits the application of any waiting period that exceeds 90 days. Plans are not required to have a waiting period, and the provision does not require plan sponsors to offer coverage to any particular employee or class of employees. This provision applies to grandfathered health plans and non-grandfathered plans.

9. Summary of Benefits and Coverage and Uniform Glossary (page 112) – (29 CFR 2590.715-2715)

The ACA provides for new disclosure tools, the Summary of Benefits and Coverage (SBC) and Uniform Glossary, to help consumers better compare coverage options available to them in both the individual and group health insurance coverage markets. Generally, group health plans and health insurance issuers are required to provide the SBC and Uniform Glossary free of charge.

10. Patient Protections

These are considered immediate market reforms.

a. Choice of Healthcare Professional – (29 CFR 2590.715-2719A(a)(1)–(3))

A plan or issuer that requires or provides for a participant or beneficiary to designate a participating primary care provider must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. The plan or issuer must permit the designation of a physician who specializes in pediatrics as a child's primary care provider, if the provider participates in the network and is available to accept the child. A group health plan or issuer that provides obstetrical or gynecological (OB/ GYN) care and requires the designation of an in-network primary care provider, may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for OB/GYN care provided by a participating health care professional who specializes in obstetrics and gynecology and authorized under State law to provide OB/GYN care, including a person other than a physician.

b. Coverage for Emergency Services – (29 CFR 2590.715-2719A(b)(2))

A plan must provide coverage for emergency services without the need for any prior authorization determination and regardless of whether the health care provider furnishing the emergency services is a participating provider with respect to the services. A plan may not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements that apply to emergency services provided in network. A plan may not impose cost-sharing requirements for emergency services received out-of-network that exceed the cost-sharing requirements for emergency services received at participating providers. However, in the absence of an agreement between the issuer or plan sponsor and the provider, an out-of-network provider may balance-bill the patient for the excess of the provider's charges over the amount the plan is required to pay under this section, together with the network-level cost sharing.

11. Preventive Services – (29 CFR 2590.715-2713(a)(1))

Group health plans must provide coverage for certain recommended preventive services, without imposing any cost sharing requirements. A complete list of recommendations and guidelines that include services that are required to be covered can be found at [Healthcare.gov/center/regulations/prevention.html](https://www.healthcare.gov/center/regulations/prevention.html). Any changes to or new recommendations and guidelines must be covered within one year after the date the recommendation or guidance is issued. Plans that utilize networks are not required to provide coverage for preventive service delivered by out-of-network providers and may impose cost-sharing for out-of-network preventive services. Plans may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the recommended preventive service to the extent not specified in the recommendation or guidelines.

12. Internal Claims and Appeals and External Review – (29 CFR 2560.503-1 and 29 CFR 2590.715-2719)

Under the Affordable Care Act, group health plans and health insurance issuers offering group health insurance coverage were required to implement an effective internal claims and appeals process for plan years beginning on or after September 23, 2010. In general, the interim final regulations require plans and issuers to comply with the DOL claims procedure rule under *29 CFR 2560.503-1* and impose specific additional requirements and include some clarifications (referred to as the “additional standards” for internal claims and appeals). In addition to meeting those requirements, the plan is required to comply with all of the requirements of the DOL claims procedure rule under *29 CFR 2560.503-1*.

Plans must also comply with either a state external review process (if fully insured) or a federal external review process (if self-funded). There are numerous notice and disclosure requirements

outlined in both the federal law and the state law. Plans must contract with at least three accredited IROs and assign those IROs on a rotating, impartial basis.

13. Prohibition on Waiting Periods that Exceed 90 days – (29 CFR 2560.715-2708)

Under the Affordable Care Act a group health plan or health insurance issuer offering group health insurance coverage shall not apply any waiting period (as defined in PHS Act section 2704(b)(4)) that exceeds 90 days. A waiting period is the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. The section does not require an employer to offer coverage to any particular individual or class of individuals, including part-time employees. The section prevents an otherwise eligible individual from being required to wait more than 90 days before coverage becomes effective.