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REGULATORY UPDATES
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FINAL RULE ON INDIVIDUAL COVERAGE HRAs (ICHRAs)

On June 13, 2019 the Department of Health and Human Services, the Department of Labor and the Internal Revenue Service jointly issued a final rule governing individual coverage health reimbursement accounts (ICHRAs).

The final rule is largely similar to the proposed rule issued last October, but it does contain a few changes.

Enrollment in Individual Plan Required - All covered persons (including dependents) must be enrolled in an individual health insurance plan while covered by the ICHRA. Allowable individual plans include coverage sold through or outside an ACA exchange, catastrophic coverage, student health insurance, and Medicare Parts A, B and C (must be all 3 parts). The allowable individual coverage must: 1) satisfy the ACA mandate banning annual limits on essential health benefits; and 2) cover ACA-mandated preventive services without cost sharing. Short-term limited-duration plans, and plans providing only excepted benefits, (dental and vision) are excluded.

If the participant loses coverage under the individual plan, they forfeit the ICHRA. (Employees who lose their coverage under the ICHRA for reasons other than failing to maintain individual coverage may qualify for COBRA.)

One Option per Class - If the plan offers an ICHRA option to any class of employees, it cannot also offer a traditional group health plan to the same class of employees.

The final rule revises the list of permissible classes somewhat, and adds a minimum class size requirement.

Allowable classes under the final rule are:

- Salaried employees*
- Non-salaried employees*
- Full-time employees*
- Part-time employees*
- Employees of a temporary hiring agency
- Seasonal employees
- Employees covered by a collective bargaining agreement
- Employees who have not satisfied the plan's waiting period
- Employees in different ACA rating (underwriting) areas*
- Non-resident aliens with no U.S.-based income
- Two or more of the listed groups combined into one class*
- New hires, i.e., employees hired after a specified date set by the employer/plan (beginning 1/1/2020)

**Minimum size requirement applies.*

Plan Trustees should rely on the advice of fund counsel with respect to changes required by the Affordable Care Act and other federal laws.

Minimum Size of Class - The minimum number of employees that can be considered a class depends on the size of the employer/plan, and only applies if the plan offers a traditional plan to one class and ICHRA to another class. If the plan has over 200 employees, the minimum class size is 20. The class size is based on the number of employees offered ICHRA coverage, not the number who actually enroll in the ICHRA.

Same Terms for All Class Members - The same amount and the same conditions must apply to all employees within the class. Different dollar amounts cannot be provided within a class except on the basis of age or family size to account for higher premiums on the individual market. Unlike the proposed rule, the final rule caps the age differential at three times the contribution made to the ICHRA for the youngest participant.

Former Employees - Terminated/retired employees can be offered an ICHRA, and the ICHRA can be provided for some, but not all, former employees in a class. The ICHRA for former employees must have the same terms as the ICHRAs provided for the current employees in the same class. Years of service cannot be taken into account when determining the amount offered to the former employees in that class. (This was another change from the proposed rule.)

Annual Coverage Substantiation Requirements - ICHRA plan administrators are required to adopt an annual verification process to substantiate that the employee is actually enrolled in an individual plan.

The final rule states that verification can be in the form of a document from the insurer such as an I.D. card, a document from an exchange showing the person has completed the pre-enrollment process and selected a plan, or an attestation from the participant.

The verification must be submitted no later than the date the ICHRA coverage begins.

Substantiation With Each Claim - The administrator must also verify enrollment in the individual plan each time a participant submits a request for funds from his/her ICHRA (a "claim"). This can be a signature on the claim form. Model attestation language is available.

Other Covered Expenses - In addition to premiums for individual health insurance, the ICHRA can be used for other types of expenses covered by a regular HRA, i.e., non-reimbursed medical expenses deemed deductible by the IRS.

Miscellaneous Requirements

- Employees may not be given a choice between an ICHRA and a traditional group health plan.
- An ICHRA can be offered in conjunction with an HSA as long as the ICHRA only reimburses individual coverage premiums.
- Plans must offer COBRA coverage when the ICHRA coverage terminates, except when the ICHRA coverage is terminated for failure to maintain individual coverage.
- Participants must be permitted to opt out of the ICHRA at least annually, and upon termination of employment.
- Employees offered an ICHRA are not eligible for the ACA's premium tax credits, as long as the ICHRA is affordable. (Under a special rule, a multiemployer plan established pursuant to (a) collective bargaining agreement(s) is considered affordable.) Participants must be notified of this on an annual basis.

Excepted Benefit HRAs (EB-HRAs) - The final rule continues to permit another new option, called an excepted benefit HRA (EB-HRA). These can be funded up to $1,800 and used to pay premiums for excepted benefits, short-term plans and COBRA premiums. The $1,800 limit will be adjusted annually for inflation.

An EB-HRA must meet four requirements:

- The EB-HRA can be offered only to participants who are eligible for the plan's traditional health plan, but it cannot be an integral part of the traditional plan;
- It must provide benefits that are limited in amount ($1,800 for 2020);
- It can cover premiums only for certain types of insurance (dental and/or vision plans, short-term coverage and COBRA premiums); and
- It must be made available under the same terms to all similarly situated individuals.

The regulations do <u>not</u> allow an HRA that is integrated with traditional medical plan to be expanded to permit participants to purchase an individual plan.

What This Means for Multiemployer Plans - The final rules clarified that multiemployer plans can offer ICHRAs and EB-HRAs subject to the same rules as employers.

Trustees may want to research whether or not an ICHRA or EB-HRA is a good option for their plan. For example, an ICHRA might be an option for part-timers or employees working toward establishing initial eligibility. The EB-HRA option could be an attractive alternative for plans that do not currently offer dental and/or vision coverage.

SECTION 1557 RELIEF COMING

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights issued a proposed rule and fact-sheet on May 24, 2019 stating that they will be revising the Section 1557 regulations.

Background - Section 1557 of the Affordable Care Act (ACA) prohibited discrimination by affected entities based on race, color, national origin, age, disability and sex. The final rule

was released in May 2016. That regulation:

- Expanded requirements to provide assistance to persons with limited English proficiency and disabilities;
- Required coverage for gender dysphoria and termination of pregnancy; and
- Contained new notice requirements and the requirement to add foreign language tags at the end of almost all communications.

Section 1557 rules apply to "every health program or activity" that receives HHS funding.

Implementation of the final rule was temporarily enjoined by a federal court (*Franciscan Alliance, Inc. et al. v. Burwell)*. The *Burwell* decision concluded that HHS did not have the legal authority to implement the gender and termination of pregnancy provisions, and that these aspects of the final rule were likely contrary to existing civil rights laws.

Proposed Changes to Final Rule - When finalized, the new rules will:

- Remove the mandates concerning gender identity and termination of pregnancy;
- Remove the notice and tagline requirements;
- No longer require covered entities to post information about Section 1557 on websites and workplaces; and
- Remove the requirement to designate at least one employee to be responsible for enforcement, and the requirement to maintain a grievance procedure.

Effective Date - The changes will become effective 60 days after publication of the final rule.

Resource - The final rule was published in the June 14, 2019 *Federal Register*.

2020 COST SHARING LIMITS

The 2020 annual out-of-pocket limit (OOPL) maximums for non-grandfathered health plans are:

- $8,150 for self-only coverage
- $16,300 for family (self + dependent(s)) coverage

These amounts are 3.8% higher than the 2019 maximums of $7,900 (self) and $15,800 (family).

Annual increases will now be based on the premium increases charged by individual and group plans. Only group premiums were previously included. It is expected that this change in methodology will result in higher allowable OOPL maximum amounts.

Resource - The 2020 Benefit and Payment Parameters were published in the April 25, 2019 *Federal Register*.

BRAND NAME DRUG COUPONS AND OUT-OF-POCKET LIMITS

When HHS issued the Benefit and Payment Parameters for 2020 on April 25, 2019, they included a new rule concerning calculating out-of-pocket costs for prescription drugs. The rule clarifies that the value of drug manufacturers' coupons (and other third-party payments) for brand-name drugs that have available generic equivalents can be excluded from the participant's deductible and out-of-pocket limit.

This policy change does not apply when a brand name drug does not have a generic equivalent, or when a plan's exceptions process has determined that a generic equivalent is either not available or not medically appropriate. In those situations, the plan must apply the coupon's value toward the patient's deductible and out-of-pocket limit.

Resource: The proposed rule was published in the April 25, 2019 *Federal Register.*

Administrators of non-grandfathered plans should work with their prescription benefit managers (PBMs) to make sure third-party Rx coupons are not being applied to deductibles and out-of-pocket limits.

WILDERNESS THERAPY?

Wilderness therapy programs have gained in popularity over the past decade. They are a form of alternative medicine for adolescents and young adults that provide residential living in a camp-like setting. A typical program will combine standard behavioral therapy with outdoor activities.

Although some participants are seeking greater self-knowledge through adventure and a change in scenery, many others have valid mental health or substance abuse diagnoses such as depression, bulimia or drug addiction. The theory is that by engaging with nature and learning some basic survival skills, the participants will gain insights into themselves and develop higher self-esteem which will, in turn, lessen their negative behaviors.

Programs often last several weeks and costs typically include an enrollment fee of approximately $1,500 - $3,000, plus daily fees that on average cost more than $500.

As with other alternative or complementary therapies, wilderness therapy has not gained wide acceptance in the mainstream medical community, and health plans and insurers have declined to pay for it. This is because wilderness therapy is not backed up by large, high-quality, controlled and randomized clinical trials.

Class Action Lawsuits - Since the release of the final regulations governing the Mental Health Parity and Addiction Equity Act (MHPAEA), several lawsuits have been filed against health plans on behalf of teen participants. The lawsuits claim that since MHPAEA regulations require health plans to cover mental health treatments on the

same terms that they cover medical and surgical care, plans cannot impose certain coverage restrictions on wilderness therapy.

The court rulings to date have been all over the map because each ruling was based on the specific language in the defendant plan. However, it appears that, at least in some jurisdictions, medical necessity and blanket exclusions may be difficult to defend because there are no similar medical/surgical treatments to which wilderness therapy can be compared.

Recommendation - Although litigation is still in progress, we recommend that trustees ask their fund counsel to review the applicable provisions in their plan documents. It may be necessary to add a blanket exclusion for wilderness therapy and similar programs that is applicable to medical/surgical as well as mental health/substance abuse benefits. For example, the plan could exclude "therapies or programs that are primarily supportive in nature, and/or that take place in a camp, ranch, park or other outdoor setting without on-site doctors, nurses or Master's-level behavioral therapists. This exclusion applies to but is not limited to wilderness therapy."

Current plan provisions for wilderness therapy should be reviewed and possibly revised by Fund Counsel.

OUTRAGEOUS AIR AMBULANCE BILLS

Health plans are scrambling for solutions to the problem of extremely high out-of-network air ambulance bills.

The Government Accountability Office (GAO) found that the median price for air ambulance services doubled from 2010 to 2014. It is not unusual to see a charge of $40,000 for a flight that has a Medicare allowable amount of $6,500. If the health plan limits its coverage to a "reasonable charge," especially if the limiting charge is based on a percentage of Medicare's allowable, the patient will be balance billed for the rest. Most air ambulance services will not negotiate or reduce their charge, leaving patients owing thousands to the air transport company, when they had no choice in using the service in the first place.

The Roots of the Problem

- Air ambulances, both fixed-wing and helicopters, are regulated by the Federal Aviation Administration (FAA) in accordance with the Airline Deregulation Act of 1978 (ADA). Because states are prohibited from regulating them, air ambulances are not required to participate in insurance networks, and they can balance bill their patients.
- Air ambulance companies argue that since 50% or more of their revenues are from Medicare and Medicaid, they have to adjust their prices upward to account for the low payment rates received from those programs.
- Two-thirds of the major helicopter ambulance services are for-profit companies owned by private equity investors. Air ambulances are very lucrative since their charges far exceed their costs.
- Although the size of the nation's air ambulance fleet has doubled since early 2002, the Government Account Office (GAO) noted in a July 2017 report that the increased competition over the past few years has not resulted in lower prices. In fact, it has had the opposite effect, as providers have raised their prices to make up for fewer flights.

Federal Legislation Pending - At this time there are no gold-standard approaches that plans can use to protect participants and the plans' assets from excessive air ambulance bills.

According to the National Association of Insurance Commissioners (NAIC), federal legislation is needed to provide a workaround to the ADA. Congress is considering three bills that address surprise bills from out-of-network providers providing emergency services. One of these bills, S.1895, would apply to air ambulance charges, but the others would not. S.1895 would require health plans to pay air ambulance charges at their in-network payment rates and use an allowable charge of their "median in-network rate." The bill holds patients harmless for the excess.

Ambulance providers say that this approach is unfair and want additional legislation that would obligate insurers to include air ambulances in their networks, presumably by paying them much more than insurers are currently willing to pay. They also claim that S.1895 (or any similar legislation) would cause air ambulance companies to cease operating.

In the meantime, administrators should continue to administer their plans' reasonable and customary charge limitations, and negotiate discounts whenever possible.

Resources - For more information, see the following sources:

- https://www.gao.gov/products/GAO-17-637
- https://khn.org/news/will-congress-bring-sky-high-air-ambulance-bills-down-to-earth/
- https://www.naic.org/cipr_topics/topic_air_ambulances.htm

REVISED RULES FOR STATE EHB PLANS

The ACA does not permit health plans to place annual or lifetime dollar limits on essential health benefits (EHBs). In addition, non-grandfathered plans cannot impose cost-sharing requirements on EHBs that exceed certain limitations. Health plans determine which benefit categories are essential by selecting an EHB benchmark plan from any state. If the benchmark plan considers a service to be an EHB, then the health plan must also consider it to be an EHB.

The Utah EHB plan is a popular benchmark plan since it does not consider services such as chiropractic and infertility to be EHBs, nor does it cover habilitative services.

The process states must follow to select their EHB plans was changed starting with the 2020 plan year. Under the new rules, states are permitted to change their plan selections, or to use another state's EHB plan for part or all of its own EHB plan.

When these new rules were announced, commenters expressed their fears that states would reduce their coverage and consider fewer services to be EHB. However, for 2020 only one state, Illinois, changed its EHB plan. In fact, Illinois improved its coverage for alternative therapies and mental health treatment.

Utah did not make any changes for 2020. Therefore, the health plans that use the Utah EHB plan as their benchmark will not have to make changes for 2020.

The option to revise EHB benchmarks applies every year, and it is possible that Utah and other states could make changes in future years.