Health Care Reform
Bulletin

Final ACA Market Reform Rules Issued

Provided by Cottingham & Butler

Quick Facts

- On Nov. 18, 2015, the Departments published final rules addressing a number of the ACA's market reform requirements.
- The final rules are effective Jan. 1, 2017.
- The final rules replace interim final rules issued on these provisions, and finalize other subregulatory guidance without any substantial changes.

The final rules address market reforms such as lifetime and annual limits, dependent coverage up to age 26 and patient protections.

The Affordable Care Act (ACA) includes certain market reforms that apply to group health plans and health insurance issuers in the group and individual markets.

On Nov. 18, 2015, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) published **final regulations** regarding a number of the ACA's market reform requirements. These final regulations address:

- Grandfathered plans;
- Pre-existing condition exclusions;
- Lifetime and annual dollar limits on benefits;
- Rescissions;
- Dependent coverage up to age 26;
- Internal and external appeals; and
- Patient protections.

These final regulations generally finalize provisions from previous interim final regulations without any substantial changes, incorporating clarifications issued by the Departments in frequently asked questions (FAQs) and other subregulatory guidance.

Grandfathered Plans

Under the ACA, group health plans and health insurance coverage existing as of March 23, 2010 (the date of the ACA's enactment)—known as "**grandfathered health plans**"—are only subject to certain ACA requirements, as long as they maintain their grandfathered status.

On June 17, 2010, the Departments issued interim final regulations on grandfathered plans, which included a number of rules related to maintaining a plan's grandfathered status. The 2015 final regulations generally finalize provisions in the interim final regulations, with certain clarifications. Specifically, the final regulations:

- Incorporate clarifications from FAQs on the application of the rules for determining grandfathered status on a benefit-package-by-benefit-package basis;
- Clarify that a disclosure of grandfathered status does not need to be included in every communication;
- Incorporate examples from FAQs on the application of certain anti-abuse rules to new or transferring employees;

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- Clarify that the addition of a new contributing employer to a grandfathered multiemployer health plan will not affect the plan's grandfathered status, provided that the multiemployer plan has not made any other changes that would cause the plan to relinquish its grandfathered status; and

- Incorporate a number of clarifications from previous guidance on rules for determining when changes to the terms of a plan or health coverage cause the plan or coverage to cease to be a grandfathered health plan.

Pre-existing Condition Exclusions

The ACA prohibits group health plans and health insurance issuers from imposing any pre-existing condition exclusions. On June 28, 2010, the Departments issued interim final regulations implementing the ACA's prohibition on pre-existing condition exclusions. The 2015 final regulations generally finalize provisions in the interim final regulations, with certain clarifications issued in subregulatory guidance.

Specifically, the final regulations:

- Reaffirm that the ACA does not prohibit a plan or issuer from excluding all benefits for a condition, provided it does so regardless of when the condition arose relative to the effective date of coverage (although other federal or state laws may prohibit certain benefits exclusions, such as the ACA's essential health benefits requirement in the individual and small group markets);

- Decline to impose any requirement on plans to offer an open enrollment period to individuals with pre-existing conditions; and

- Incorporate a clarification from an FAQ that allows issuers to screen certain applicants for eligibility for alternative coverage before issuing a child-only policy under certain circumstances, if permitted by state law.

Lifetime and Annual Limits

The ACA prohibits health plans from imposing lifetime and annual dollar limits on essential health benefits (EHB). This prohibition applies to both non-grandfathered and grandfathered group health plans. However, it does not apply to grandfathered individual policies.

On June 28, 2010, the Departments issued interim final regulations implementing this prohibition. The 2015 final regulations generally finalize provisions in the interim final regulations, incorporating certain clarifications issued in subregulatory guidance. Specifically, the final regulations:

- Incorporate a clarification from an FAQ that allows a self-insured group health plan, a large group market plan or a grandfathered group health plan to define EHB using one of the potential EHB base-benchmark plans that states could have chosen from as the standard for EHB in their state;

- Clarify that lifetime and annual dollar limits on EHB are generally prohibited, regardless of whether benefits are provided on an in-network or out-of-network basis;

- Reiterate that the waiver program allowing restricted annual dollar limits has ended, and that waivers are no longer available; and

- Incorporate guidance from an FAQ and other subregulatory guidance regarding the application of the annual dollar limit prohibition to account-based plans, including clarifying rules for integrating health reimbursement arrangements (HRAs) and other account-based plans with group health plans, reiterating that these plans cannot be used to purchase individual plan premiums and establishing rules for using these plans to pay Medicare premiums.

Rescissions

The ACA prohibits group health plans and health insurance issuers from rescinding coverage for covered individuals, except in cases of fraud or intentional misrepresentation of material facts. This prohibition applies to grandfathered and non-grandfathered health plans, whether in the

group or individual market, and whether coverage is insured or self-funded.

On June 28, 2010, the Departments issued interim final regulations regarding these health plan coverage mandates. The 2015 final regulations generally finalize provisions in the interim final regulations, incorporating certain clarifications issued in subregulatory guidance.

Specifically, the final regulations:

- Decline to define the term "material fact" as it relates to rescissions of coverage, but note that previous final regulations stated that an individual who is found to have reported false or inaccurate information about his or her tobacco use may be charged the appropriate premium that should have been paid retroactive to the beginning of the plan year, but that coverage cannot be rescinded;
- Incorporate a clarification from an FAQ that a "rescission" does not include a retroactive elimination of coverage due to a delay in administrative recordkeeping;
- Clarify that a retroactive cancellation or discontinuance of coverage is not a "rescission" if the individual voluntarily initiates the cancellation or an Exchange requests the cancellation;
- Clarify that rescissions of coverage are eligible for internal claims and appeals and external review for non-grandfathered health plans, whether or not the rescission has an adverse effect on any particular benefit at the time of an appeal;
- Clarify that the exception for the failure to pay required premiums or contributions on time also includes a failure to pay required COBRA premiums; and
- Reiterate that a plan or issuer must provide at least 30 days advance written notice to individuals stating the reason(s) for an adverse benefits determination or final internal adverse benefits determination (including a rescission of coverage) and a description of available internal appeals and external review processes, including information on how to initiate an appeal.

Dependent Coverage up to Age 26

The ACA requires group health plans and health insurance issuers that offer group or individual coverage that provides dependent coverage to children on their parents' plans to make coverage available until the adult child reaches age 26.

On May 13, 2010, the Departments published interim final regulations on the ACA's young adult coverage requirement. The 2015 final regulations generally finalize provisions in the interim final regulations, incorporating certain clarifications issued in subregulatory guidance.

Specifically, the final regulations:

- Clarify that a plan or issuer may not deny or restrict coverage for a child under age 26 based on the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment or any combination of those factors;
- Includes an additional clarification that eligibility restrictions under a plan or coverage that require individuals to work, live or reside in a service area violate the young adult coverage requirement, to the extent that the restrictions are applicable to dependent children up to age 26, even if they are intended to apply generally to all participants and beneficiaries;
- Reiterate that plans or issuers are not required to make coverage available to grandchildren, and clarify that the term "child" includes a son, daughter, stepson, stepdaughter or adopted child of the participant;
- Incorporate examples from the interim final regulations reiterating that the terms of the plan or health insurance coverage providing

dependent coverage of children cannot vary based on the age of a child, except for children age 26 or older (although the cost of coverage increases for tiers with more covered individuals that apply without regard to the age of any child do not violate this requirement); and

- Incorporate a clarification from an FAQ illustrating that distinctions based on age that apply to all coverage under the plan are permissible.

Internal and External Appeals

The ACA requires non-grandfathered group health plans and health insurance issuers to adopt an improved process for internal claims and appeals and to follow minimum requirements for external review.

On July 23, 2010, the Departments issued an interim final rule implementing the ACA's internal claims and appeals and external review requirements. The 2015 final regulations generally finalize provisions in the interim final regulations, incorporating some of the enforcement safe harbors, transition relief and clarifications in subregulatory guidance.

Contemporaneous with the 2015 final rules, the Departments also published separate proposed regulations to amend the DOL claims procedure regulations, as applied to plans providing disability benefits. The amendment would revise and strengthen the current DOL claims procedure regulations regarding claims and appeals applicable to plans providing disability benefits, primarily by adopting the protections and standards for internal claims and appeals applicable to group health plans.

Patient Protections

The ACA imposes three requirements on group health plans and group or individual health insurance coverage that are referred to as "patient protections" related to the **choice of a health care professional** and requirements relating to **benefits for emergency services**. The ACA's patient protections do not apply to grandfathered plans. Also, the rules regarding choice of health care professional apply only to plans that have a network of providers.

On June 28, 2010, the Departments issued interim final regulations regarding these health plan coverage mandates. The 2015 final regulations generally finalize provisions in the interim final regulations, incorporating certain clarifications issued in subregulatory guidance. Specifically, the final regulations:

- Decline to clarify the rules in instances where a participant, beneficiary or enrollee is incapacitated, although they do note that a duly authorized representative may act on behalf of a participant or beneficiary to the extent permitted under other applicable federal and state law;
- Decline to define "primary care provider," instead allowing this term to be determined under the terms of the plan or coverage (and in accordance with applicable state law);
- Clarify that a plan or issuer may not require authorization or referral by the plan, issuer or any person (including a primary care provider) for a female participant, beneficiary or enrollee who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics or gynecology;
- Clarify that the ACA ensures direct access to obstetrical and gynecological care for all women, regardless of age;
- Clarify that plans and issuers are not prohibited from applying reasonable and appropriate geographic limitations with respect to which participating primary care providers are considered available for purposes of selection as primary care providers, in accordance with the terms of the plan, the underlying provider contracts and applicable state law; and
- Clarify the interaction between minimum payment rules and state laws prohibiting balance billing for emergency services.