Final Rules Issued on Several 2010 ACA Insurance Reforms

The final rules, issued by Administration on November 13, 2015, are effective January 1, 2017. They incorporate interim rules and regulatory guidance issued since June 2010, largely reinforcing and clarifying the details.

❖ Grandfathered Plans

The final rules confirm that:

- An employer can determine grandfathering independently for each health plan offered.
- Plan sponsors must continue to include a statement that they believe their plan is grandfathered and contact information for questions/complaints in any benefit summaries provided.
- If a change is made mid-year that causes a loss of grandfathered status, the loss is effective immediately, not at the beginning of the next plan year.
- The following changes will result in a loss of grandfathered status:
    - The plan eliminates "substantially all benefits" needed to diagnose or treat a particular condition.
    - The plan has an increase in copayment above the allowed amount for one type of service, even if copayments for other services are not increased.

❖ Preexisting Condition Exclusions

Exclusions for preexisting conditions were no longer allowed for individuals under age 19 in 2010 and for all individuals in 2014. The final regulations affirmed these rules without any substantial changes.

❖ Lifetime and Annual Limits

Lifetime and annual dollar limits on essential health benefits (EHBs) are prohibited, regardless of whether the benefits are provided in-network or out-of-network. This clarification is significant since plans currently apply this rule only to in-network benefits.

❖ Rescissions

The final regulations clarify that COBRA coverage can be terminated retroactively if premiums are not paid on a timely basis. Terminating coverage in this situation does not violate the prohibition on rescissions.

Individuals who provide inaccurate information about tobacco use may be charged higher tobacco premiums retroactive to the beginning of the plan year. But, coverage may not be terminated due to misrepresentation in this situation.

❖ Dependent Coverage

The regulations confirm that dependent children up to age 26 cannot be required to live in the plan's service area to be eligible for coverage.

Some HMO plans require covered individuals to live within a stated geographic area—when a child under age 26 is away at college, he/she loses eligibility. This now will be deemed to violate the adult child coverage mandate. For dependents other than children (e.g., grandchildren), a plan may impose residence, financial dependence or similar coverage requirements.

❖ Patient Protections

Designating a Primary Care Physician: For plans that require participants to choose a primary care physician, the final rules permit insurers to require plan participants to use in-network groups within certain geographic limits when making this selection.

Emergency Care: Health plans cannot charge a plan participant more for emergency care received out-of-network. Under the final rules, plans must pay for out-of network emergency services at least the greatest of: 1) the median amount paid to network providers; 2) the product of the formula that the plan uses generally for out-of-network services; or 3) the Medicare payment amount.

❖ Appeals & Review

Plans no longer may condition external review on payment of a filing fee, with one exception. In states with laws expressly permitting nominal filing fees, a plan may charge a fee up to $25 per appeal (limited to $75 annually per claimant) if the plan refunds fees paid for successful appeals and waives fees that would impose a financial hardship.

Self-insured plans and insurers in states that do not have external review provisions that meet the National Association of Insurance Commissioner's (NAIC) Model Act standards are required to use an external review process that meets HHS standards.

You can access the full text of the Final Regulations here.