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Health Care Reform Alert

November 17, 2015

Final Regulations Issued on Several 2010 Provisions

On November 13, the Departments of Health and Human Services (HHS), Labor and Treasury issued final regulations regarding Lifetime and Annual Limits, Grandfathered Plans, Preexisting Condition Exclusions, Rescissions (Cancellation of Coverage), Dependent Coverage, Primary Care Physicians, Emergency Care, and Appeals and Review.

These final regulations apply to individual and group health plans for plan years beginning on or after January 1, 2017.

The interim final rules for these provisions have been in effect since 2010, and additional guidance has been issued on some provisions over the past several years. The final rules reflect updates made since 2010 and, largely, reinforce or clarify the details.

Implications for Expatriate Plans: These final regulations do not address applicability, if any, to expatriate health plans and indicate that insurers, employers and plan sponsors should continue to follow the interim guidance under the Expatriate Health Coverage Clarification Act (EHCCA) until the IRS issues further guidance.

Here are the highlights of the final regulations. Cigna will continue to review and assess the impact to our health plans.

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.

Grandfathered Plans

The final rules confirmed the following:

- 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 and complaints in any benefit summaries provided. The sample language provided in the regulations may be used, but it is not required.
- 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 regulations did not provide further clarification of “substantially all benefits.”
  - 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 the rules without any substantial changes.

Rescissions (Cancellation of Coverage)

The regulations clarified 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. However, coverage may not be terminated due to misrepresentation in this situation.

Dependent Coverage

The regulations confirmed that dependent children up to age 26 cannot be required to live in the plan’s service area to be eligible for coverage. This regulation relates only to eligibility and does not require a plan such as an HMO to cover services provided outside the plan’s service area.

For example, an HMO would be required to cover a college student attending school outside the plan’s service area, but would not be required to cover out-of-network care received outside of the plan’s network, except for emergencies.

Designating a Primary Care Physician

For plans that require participants to choose a primary care physician, the final rules allow health plans and insurers to require plan participants to use in-network groups within certain geographic limits when selecting a primary care physician.

Emergency Care

Health plans cannot charge a plan participant more for emergency care received out-of-network. The final regulations permit balance billing for emergency care, although existing state laws prohibiting balance billing must still be followed. Plans and insurers must provide notice in the summary plan description about whether balance billing may result from using an out-of-network provider for emergency care.

Appeals and Review

The final rules contain extensive language about internal and external appeal and review processes. Over the past several years, additional guidance including FAQs, technical releases and amendments have been issued. The final rules adopted much of this guidance.

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. HHS has allowed plans to use "NAIC-similar" external review processes that do not meet all of the requirements of the NAIC Model Act for a transitional period. The final regulations extended this transitional period until December 31, 2017.

Read the final regulations

We encourage you to bookmark Cigna's health care reform website, InformedOnReform.com, where we will update information as future guidance and final rules are released.