# ACA COMPLIANCE OVERVIEW

## Pre-existing Condition Exclusions

The Affordable Care Act (ACA) amended the rules regarding pre-existing condition exclusions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The HIPAA rules applied only to group health plans and group health insurance coverage, and allowed limited exclusions of coverage based on pre-existing conditions under certain circumstances. However, the ACA rules:

- Prohibit any pre-existing condition from being imposed by group health plans or group health insurance coverage; and
- Extend this protection to individual health insurance coverage.

This prohibition generally became effective with respect to plan years beginning on or after Jan. 1, 2014. However, for enrollees who are under 19 years of age, this prohibition took effect for plan years beginning on or after Sept. 23, 2010.

### LINKS AND RESOURCES

- On June 28, 2010, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (Departments) issued interim final rules on the pre-existing condition exclusion prohibition.
- On Nov. 18, 2015, the Departments finalized the interim final rules without substantial change, incorporating clarifications from FAQs and other subregulatory guidance.

## Overview

The ACA amended the HIPAA rules regarding pre-existing condition exclusions. The HIPAA rules:

- Applied only to group health plans and group health insurance coverage; and
- Allowed limited coverage exclusions based on pre-existing conditions under certain circumstances.

## Covered Plans

The ACA's prohibition on pre-existing condition exclusions apply to:

- Group health plans and group health insurance coverage, including grandfathered group health plans; and
- Individual health insurance coverage (but not grandfathered individual policies).

## Covered Plans

The ACA's pre-existing condition exclusion rules apply to group health plans and group health insurance coverage, including grandfathered group health plans. The rules also apply to individual health insurance coverage, although they do not apply to grandfathered individual policies.

Grandfathered plans are group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010 (the date that the ACA was passed). Grandfathered plans are not subject to certain ACA provisions, so long as they retain their grandfathered status. A grandfathered plan will retain its grandfathered status even if covered individuals renew their coverage after **March 23, 2010**, family members are added to coverage or new employees (and their families) enroll for coverage. However, plans will lose their grandfathered status if they choose to make certain changes, such as **significantly cutting benefits** or **increasing out-of-pocket spending** for participants.

## Pre-existing Condition Exclusion Defined

A pre-existing condition exclusion is a limitation or exclusion of benefits related to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.

> Based on this definition, the ACA prohibits both **exclusions of coverage of specific benefits** and **complete exclusions from a plan or coverage** based on a pre-existing condition.

However, the ACA's pre-existing condition exclusion rules do not change the HIPAA rule that an exclusion of benefits for a certain condition under a plan **that is not based on the date the condition** arose is not a pre-existing condition exclusion. For example, if a group health plan generally provides coverage for medically necessary services, but excludes coverage for the treatment of cleft palate, the exclusion of coverage for treatment of cleft palate is not a pre-existing condition exclusion because it applies regardless of when the condition arose.

Other federal or state law requirements, however, may prohibit certain benefit exclusions, including the ACA's essential health benefits requirements applicable in the individual and small group health insurance markets.

### Clarifications

The ACA does not impose any requirement on plans to provide an open enrollment period for individuals with pre-existing conditions. Although HIPAA generally permits plans and issuers to treat participants and beneficiaries with adverse health factors more favorably (such as providing a longer open enrollment period) nothing in the final regulations requires plans and issuers to do so.

Also, the Departments clarified in an FAQ that, in certain circumstances, states can allow issuers in the individual market to screen applicants for eligibility for alternative coverage options before offering a child-only policy if:

1. The practice is permitted under state law;
2. The screening applies to all child-only applicants, regardless of health status; and
3. The alternative coverage options include options for which healthy children would potentially be eligible, such as the Children's Health Insurance Program (CHIP) and group health insurance.

Screenings may not be limited to programs targeted to individuals with a preexisting condition, such as a state high risk pool. Also, Medicaid policy prohibits participating states from allowing health insurance issuers to consider whether an individual is eligible for, or is provided medical assistance under, Medicaid in making enrollment decisions.

Furthermore:

- Issuers may not implement a screening process that by its operation significantly delays enrollment or artificially engineers eligibility of a child for a program targeted to individuals with a preexisting condition; and
- The screening process may not be applied to offers of dependent coverage for children.

The FAQ provided that states are encouraged to require issuers that screen for other coverage to enroll and provide coverage to the applicant effective on the first date that the child-only policy would have been effective had the applicant not been screened for an alternative coverage option. It also provided that states are encouraged to impose a reasonable time limit (such as 30 days) at which time the issuer would have to enroll the child regardless of pending applications for other coverage. The ACA's guaranteed availability requirements similarly preclude an issuer from denying coverage.