



Bulletin No. B-4.34

Immediate Market Reforms Involving the Federal Patient Protection and Affordable Care Act (ACA)

I. Background and Purpose

The purpose of this bulletin is to provide guidance on the immediate market reforms of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [together referred to as the “Affordable Care Act” (ACA)]. Carriers are not only required to comply with Colorado’s laws, but also all applicable laws, in the conduct of their business.

Bulletins are the Colorado Division of Insurance’s (“Division”) interpretations of existing insurance law or general statements of Division policy. Bulletins themselves establish neither binding norms nor finally determine issues or rights.

II. Applicability and Scope

This bulletin is to provide guidance to all carriers offering group or individual health coverage as defined in §10-16-102(8), C.R.S. and, including carriers offering coverage under Parts 2, 3, and 4 of Article 16 of Title 10 which coverage is subject to the requirements of the ACA. For purposes of this bulletin, under the ACA, the following benefits are excepted from coverage:

1. Coverage only for accident, or disability income insurance, or any combination thereof.
2. Coverage issued as a supplement to liability insurance.
3. Liability insurance, including general liability insurance and automobile liability insurance.
4. Workers’ compensation insurance or similar insurance.
5. Automobile medical payment insurance.
6. Credit-only insurance.
7. Coverage for on-site medical clinics.
8. If offered separately:
 - a. Limited scope dental or vision benefits.
 - b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
9. If offered as independent, noncoordinated benefits:
 - a. Coverage only for a specified disease or illness.
 - b. Hospital indemnity or other fixed indemnity insurance.
 - c. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act and coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code and similar supplemental coverage provided to coverage under a group health plan.
10. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

See Section 2791(c) of the Public Health Service Act, 42 U.S.C. 300gg-91.

III. Division Position

With the enactment of the ACA, it is important that carriers ensure their policy forms and rates comply with these recently enacted federal laws, federal regulations promulgated under this statutory authority, and state laws and regulations. Colorado law requires that rates are not excessive, inadequate or unfairly discriminatory, §10-16-107, C.R.S. Policy forms or rates that do not comply with the provisions of federal and state law and regulation may be found to be in violation of §10-16-107, C.R.S.

A. General Provisions: The health insurance market reforms adopted as part of ACA are phased-in over the next 5 years. Most provisions will not take effect until January 1, 2014. However, some new protections are effective for plan years beginning on or after September 23, 2010:

1. A carrier offering group or individual health coverage may rescind coverage only for fraud or intentional misrepresentation of material fact as specified in the policy and permitted pursuant to Patient Protection and Affordable Care Act, sec. 2712 (to be codified at U.S.C.A. § 18001 Note). Prior notification must be made to individual or group policyholders before a policy can be cancelled. Patient Protection and Affordable Care Act, sec. 2712 (to be codified at U.S.C.A. § 18001 Note), and Interim Final Rule, Patient Protection and Affordable Care Act: Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections, 75 Fed. Reg. 37188, (June 28, 2010) (to be codified at 26 C.F.R. pt. 54, 602, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 144-147) [Patient Protections Interim Final Rule].
2. A carrier offering group or individual health coverage may not establish a lifetime limit maximum. Patient Protection and Affordable Care Act, sec. 2711 (to be codified at U.S.C.A. § 18001 Note) and Patient Protections Interim Final Rule.
3.
 - a. A carrier offering group or individual health coverage may only establish a restricted annual limit on benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits of the Patient Protection and Affordable Care Act, sec 1302(b) (to be codified at 42 U.S.C.A. § 300gg-11), as determined by the U.S. Secretary of Health and Human Services (HHS). Patient Protection and Affordable Care Act, sec. 2711 (to be codified at U.S.C.A. § 18001 Note) and Patient Protections Interim Final Rule.
 - b. The Patient Protection and Affordable Care Act, sec 1302(b) (to be codified at 42 U.S.C.A. § 300gg-11) includes the following general categories, and items and services covered within such categories to be considered “essential health benefits”:
 - (1) Ambulatory patient services;
 - (2) Emergency services;
 - (3) Hospitalization;
 - (4) Maternity and newborn care;
 - (5) Mental health and substance abuse disorder services, including behavioral health treatment;

- (6) Prescription drugs;
- (7) Rehabilitative and habilitative services and devices;
- (8) Laboratory services;
- (9) Preventive and wellness services and chronic disease management;
- (10) Pediatric services, including oral and vision care.

Patient Protection and Affordable Care Act, sec. 2711 (to be codified at U.S.C.A. § 18001 Note).

- 4. A carrier offering employer group and new individual health coverage are expected not to impose preexisting condition limitations for individuals 19 and under. Patient Protection and Affordable Care Act, sec. 2704 (to be codified at U.S.C.A. § 1800 Note) and Patient Protections Interim Final Rule.
- 5. A carrier offering group and individual health insurance coverage that provides dependent coverage must extend coverage to adult children up to age 26. Carriers are not required to cover children of adult dependents. The Secretary of HHS will define which adult children coverage must be extended. Patient Protection and Affordable Care Act, Sec 2714 (to be codified at U.S.C.A. § 1800 Note) and Interim Final Rule, Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27122 (May 13, 2010) (to be codified at 26 C.F.R. pt. 54, 602, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 144-147) [Dependents to Age 26 Interim Final Rule].
- 6. A carrier offering group health coverage is prohibited from discriminating in favor of highly compensated employees of employers under section 105(h)(2) of the Internal Revenue Code of 1986. Patient Protection and Affordable Care Act, sec 2716 (to be codified at U.S.C.A. § 1800 Note).
- 7. A carrier offering group and individual health coverage is expected, at a minimum, to provide coverage without cost sharing for the following:
 - a. Evidence-based items and services that have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force;
 - b. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control;
 - c. Evidenced-informed preventive care and screenings for infants, children and adolescents comprehensive guidelines supported by the Health Resources and Services Administration; and
 - d. Additional preventive care and screenings for women, not provided in (a) above, as provided in comprehensive guidelines supported by the Health Resources and Services Administration. The breast cancer screening, mammography, and prevention, in the current recommendations of the United States Preventive Service Task Force, shall be considered the most current other than those issued around November 2009.
 - e. Nothing prohibits carriers from providing coverage for services in addition to those recommended by the U.S. Preventive Services Task Force, the Centers for Disease Control, or the Health Resources and Services Administration, or to deny coverage for services that are not recommended by such entities.

Patient Protection and Affordable Care Act, sec. 2713, (to be codified at U.S.C.A. § 1800 Note) Interim Final Rule, Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726 (July 19, 2010) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 147) [Patient Protections Interim Final Rule].

8. A carrier offering group and individual health coverage must allow an enrollee with a child to designate any willing participating pediatrician as the primary care provider for a child. Patient Protection and Affordable Care Act, sec. 2719A (42 U.S.C.A. § 300gg-19a) and Patient Protections Interim Final Rule.
9. A carrier offering group health coverage must permit each participant or beneficiary to designate any willing participating primary care provider. Patient Protection and Affordable Care Act, sec. 2719A (42 U.S.C.A. § 300gg-19a) and Patient Protections Interim Final Rule.
10. A carrier offering group and individual health coverage must cover gynecological and obstetric care by a network gynecologist or obstetrician without prior authorization or referral. Patient Protection and Affordable Care Act, sec. 2719A (42 U.S.C.A. § 300gg-19a) and Patient Protections Interim Final Rule.
11. A carrier offering group and individual coverage must cover emergency services without prior authorization and must cover as an in-network benefit. Patient Protection and Affordable Care Act, sec. 2719A (42 U.S.C.A. § 300gg-19a) and Patient Protections Interim Final Rule.

B. Filing Submissions

1. When submitting filings pertaining to ACA policy forms or policy form benefit modifications related to ACA, use the Filing Type of “FORM” and the appropriate TOI/Sub-TOI codes for the policy being submitted. The State Specific Code of “649 – Health Care Reform 2010” must be entered into the SERFF filing.
2. When a form filing is submitted for a benefit modification regarding ONLY ACA changes, the requirements of §10-16-201.5(8), C.R.S. do not apply. The cover letter for such filing should clearly state the modifications that are being made to comply with ACA requirements and should give the rating impact for each modification. The Filing Type for this filing should be “FORM” and the appropriate TOI/Sub-TOI codes for the policy being submitted. The State Specific Code of “649 – Health Care Reform 2010” must be entered into the SERFF filing.
3. When a filing is submitted for non-ACA changes or reasonable modifications, as detailed in §10-16-201.5, C.R.S., and Colorado Insurance Regulation 4-2-27, the non-ACA changes are required to be filed separately and as required for any other modification under §10-16-201.5, C.R.S. The Filing Type for this filing should be “OTHER/OTHER” and the TOI/Sub-TOI codes “H21.000” (or for HMOs: “Horg03.000”) for the policy being submitted. The State Specific Code of “750 – Reasonable Modifications” must be entered into the SERFF filing.

- C. Grandfathered Plans:** Premium Renewal Notices must clearly state whether the individual or group health coverage would lose grandfathered status, if there is a change in deductible or coinsurance amounts and that change were accepted by the individual or group. Health Care and

Education Reconciliation Act, sec. 2301(a) amending Patient Protection and Affordable Care Act, sec. 1251(a) (to be codified at 42 U.S.C.A. § 18011) and Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34537 (June 17, 2010) (to be codified at 26 C.F.R. pt. 54, 602, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147) [Grandfathered Health Plans Interim Rule].

- D. Conflict of Laws: The requirements of both federal and state law and regulation are expected to be incorporated to the extent they do not conflict. The provisions of the ACA are not to be construed to supercede any provisions of state law which establish, implement, or continue in effect any standards or requirements in connection with group or individual health coverage except to the extent that such standard or requirement prevents, in whole or in part, the application of a requirement of the ACA. State laws or regulations that impose requirements that are stricter than the requirements of the ACA will not be superseded by the ACA.

IV. Additional Division Resources

A. For More Information

Colorado Division of Insurance
Rates and Forms Section
1560 Broadway, Suite 850
Denver, CO 80202
Tel. 303-894-7499
Internet: <http://www.dora.state.co.us/insurance>

B. Related Division Regulations

V. History

- Issued August 2, 2010
- Revised and reissued, August 4, 2010