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Health Care Reform: Interim Final Regulations Released for Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

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On June 23, 2010, the Departments of Labor, Health and Human Services, and Treasury released final interim regulations (the "Regulations") relating to preexisting condition exclusions, lifetime and annual limits, rescissions, and other patient protections under the Affordable Care Act (the "Act").[1] The Regulations will be published in the June 28, 2010 *Federal Register*. The table below contains a brief description of each regulation, its effective date, and its application to grandfathered group health plans. (Read our alert entitled "Health Care Reform: Grandfathered Health Plan Interim Final Regulations Released" for more information on grandfathered plans.)

Regulation	Effective For Plan Years Beginning On or After	Applies to Grandfathered Group Health Plans?
Prohibition of preexisting condition exclusions or other discrimination based on health status	January 1, 2014, or for individuals under age 19, September 23, 2010	Yes
No lifetime or annual limits	September 23, 2010	Yes
Prohibition on rescissions	September 23, 2010	Yes
Patient protections	September 23, 2010	No

Prohibition of Preexisting Condition Exclusions

Under the Act, effective for plan years beginning on or after September 23, 2010, a group health plan, including a grandfathered plan, may not impose any preexisting condition exclusion for any individual under age 19. The age limit is removed for plan years beginning on or after January 1, 2014, at which time group health plans will be prohibited from applying a preexisting condition exclusion to any participant.

The Regulations provide relatively few guidelines regarding the prohibitions on preexisting condition exclusions. They do confirm that for the purposes of the Act, the definition of a preexisting condition remains the same as provided by HIPAA.[2] Accordingly, a preexisting condition is a health condition or illness that was present before an individual's effective date of coverage in the health plan, regardless of whether any medical advice was recommended or received before that date. A preexisting condition exclusion is any limitation or exclusion of benefits (including a denial of coverage) that applies to an individual due to the individual's health status before the effective date of coverage under the health plan.

Under HIPAA, group health plans are required to offset any preexisting condition exclusion period by any prior period of health insurance coverage maintained by the participant, as long as he or she did not incur a break in coverage of greater than 63 days. HIPAA's preexisting condition exclusion rules remain in effect until the new rules apply.

If, for example, an employee begins employment on October 15, 2010 and joins the employer's group health plan on that day, and the employee (and his 17 year old child) has incurred a greater than 63 day break in health insurance coverage prior to enrollment, the plan may impose its preexisting condition exclusion on the employee's 17 year old child with respect to the child's asthma, which the child had prior to joining the plan. Once the employer's new plan year commences on January 1, 2011, however, the exclusion can no longer be enforced. As of January 1, 2011, the plan must cover the asthma treatments (if they are otherwise covered). The exclusion is lifted regardless of the fact that the preexisting condition exclusion was imposed by the plan prior to the effective date of the Act for the employer's plan.

No Lifetime or Annual Limits

Lifetime Limits. Effective for plan years beginning on or after September 23, 2010, a group health plan, including a grandfathered plan, may not establish any lifetime limit on the dollar amount of essential health benefits for any individual.

Essential health benefits include, at a minimum, items and services in the following categories: ambulatory patient services; emergency services; hospitalization, maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Note: the rules on lifetime limits do not prohibit a group health plan from excluding all benefits for a condition (though other state or federal laws may apply); however, if any benefits are provided for a condition, the rules on lifetime limits apply. Furthermore, the Regulations do not limit the ability of a group health plan to impose lifetime or annual limits on non-essential health benefits.

Annual Limits. Effective for plan years beginning on or after September 23, 2010, a group health plan (other than a health care flexible spending arrangement ("health FSA")), including a grandfathered plan, in general and except as provided by the Regulations, may not establish any annual limit on the dollar amount of essential health benefits.

With respect to a group health plan that is a health reimbursement arrangement ("HRA"), the fact that benefits under the HRA may be limited does not violate the Act's restrictions on annual limits provided that the HRA is integrated with a group health plan that complies with the Act's restrictions on annual limits. It is unclear how the annual limit rules will apply to *stand-alone HRAs.* The agencies are currently seeking comments on the prohibition on annual limits with respect to stand-alone HRAs that are not retiree-only plans (retiree-only plans are generally not subject to the Act).

Exception for Restricted Annual Limits. With respect to plan years beginning prior to January 1, 2014, a group health plan, including a grandfathered plan, may establish an annual limit for any individual on the dollar amount of essential health benefits, but the annual limit may not be less than:

- $750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011
- $1,250,000 for plan years beginning on or after September 23, 2011 but before September 23, 2012
- $2,000,000 for plan years beginning on or after September 23, 2012 but before January 1, 2014

For plan years beginning on or after January 1, 2014, a plan may not impose any annual limit on essential health benefits. When determining whether an individual has reached a group health plan's annual limit, only essential health benefits are taken into account.

Note that lowering a plan's annual limit or imposing a new annual limit may result in the loss of grandfather status. (Read our alert entitled "Health Care Reform: Grandfathered Health Plan Interim Final Regulations Released".)

Program for Limited Benefit or "Mini-Med" Plans. For plan years beginning before January 1, 2014, the Secretary of Health and Human Services ("HHS") may establish a program under which the minimum annual limit requirement will be waived if establishment of such limits would result in a significant decrease in access to benefits under the plan or would significantly increase premiums. This program is intended to provide relief to employees with limited benefit plans or so-called "mini-med" plans, which might otherwise be forced to eliminate benefits or significantly increase premiums. Additional guidance regarding the waiver process is expected from HHS in the near future.

Notice of Special Enrollment Requirement. No later than the first day of the first plan year beginning on or after September 23, 2010, all group health plans must provide written notice to any individual who has lost coverage because he or she reached a lifetime limit on benefits. The notice must state that the lifetime limit no longer applies and that the individual (if still otherwise eligible) has a 30 day special enrollment period by which to enroll in any benefit option under the plan available to similarly situated employees. The notice may be included with other enrollment materials provided that it is prominent, and may be provided to an employee on behalf of a dependent. The enrollment opportunity must be provided and coverage elected pursuant to the notice will be retroactive to the first day of the plan year.

Note: On or before the first day of the first plan year beginning after September 23, 2010, employers must provide a similar special enrollment notice to all employees regarding the special enrollment rights for children under the age of 26. (Read our alert entitled "Health Coverage For Children To Age 26: Interim Final Regulations" for more information.) Employers may want to consider consolidating these notices.

Prohibition on Rescissions

Effective for plan years beginning on or after September 23, 2010, a group health plan, including a grandfathered plan, may not terminate coverage retroactively (i.e., rescind coverage) except in the case of fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A group health plan or health insurance issuer must provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded in accordance with the Act.

Example: An employer sponsors a group health plan that provides coverage for full time employees. A full time employee covered under the plan is reassigned to a part-time position; however, the plan mistakenly continues coverage. After a routine audit, the plan discovers that the employee no longer works full time. The plan rescinds the employee's coverage effective as of the date that the employee changed from full time to part-time status. This rescission violates the Act because there was no fraud or an intentional misrepresentation of material fact; however, the plan may cancel the employee's coverage prospectively, subject to other applicable state and federal and laws.

Note: A showing of "fraud or intentional misrepresentation" will be a high standard to meet. Employers should have their summary plan descriptions, enrollment and other plan communications documents carefully reviewed by qualified counsel to determine whether any ambiguous terms or provisions could provide the basis for an assertion that a representation was merely inadvertent and not intentional. For example, if the term "spouse" is not defined, an employee with a common-law spouse could claim that the inclusion of the common-law spouse was inadvertent and not an intentional misrepresentation, even in states where common-law marriage is not recognized.

Patient Protections

The patient protection provisions of the Regulations cover a set of three requirements related to choice of health care professionals and requirements relating to emergency services. The patient protections discussed below are effective for plan years beginning on or after September 23, 2010, and are not applicable to grandfathered plans.

Choice of Health Care Professional. If a group health plan requires or provides for the designation by a participant of a primary care provider, the participant must be permitted to designate any participating primary care provider who is accepting new patients. With respect to a child, any participating physician who specializes in pediatrics (allopathic or osteopathic) can be designated as the child's primary care provider. In addition, the Regulations provide that a group health plan may not require authorization or referral for obstetrical or gynecological care provided by a participating OB/GYN specialist. Note that group health plans that have not negotiated with any provider for the delivery of health care (i.e., have not created networks of coverage) but merely reimburse participants for certain medical expenses are not subject to the requirements of this paragraph.

Notice Requirements. A group health plan that requires or provides for the designation by a participant of a primary care provider must notify participants of their right to designate any primary care provider whenever the plan provides a summary plan description or other similar description of benefits available under the plan. The notice must state that with respect to a child, any participating physician who specializes in pediatrics can be designated as the child's primary care provider. In addition, the plan must notify participants that it may not require authorization or referral for obstetrical or gynecological care provided by a participating OB/GYN specialist. The Regulations include model language to satisfy the three notice requirements contained in this provision.

Coverage of Out-Of-Network Emergency Services. If a group health plan provides any benefits with respect to emergency hospital services, it must do so without requiring prior authorization or higher cost sharing amounts, even for services provided out-of-network, and it must do so without regard to any other requirement except applicable cost-sharing and other permitted exclusions (e.g., waiting periods, coordination of benefits, etc.). In other words, coinsurance and copayment amounts must be the same in-network and out-of-network; however, the Regulations permit out-of-network providers to "balance bill" participants (i.e., the provider may charge the excess of the out-of-network provider rate over the amount the plan pays), provided that the plan pays an amount equal to the greatest of three possible amounts:

- The median of all negotiated rates with network providers for the emergency service furnished, excluding any participant cost sharing amounts;
- The amount for the plan pays for out-of-network benefits (e.g., the usual, customary and reasonable amount ("UCR")), reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency services were provided in-network; and
- The amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant.

In addition, cost-sharing requirements other than copayments or coinsurance (such as a deductible or out-of-pocket maximum) may apply to out-of-network emergency services to the extent that such deductible or out-of-pocket maximum would apply to non-emergency out-of-network services.

The Regulations provide several examples that illustrate the coverage requirement for out-of-network emergency services. To calculate the median rate described above, consider the following example: If for a given emergency service a plan negotiated a rate of $100 with three providers, a rate of $125 with one provider, and a rate of $150 with one provider; the amounts taken into account to determine the median would be $100, $100, $100, $125, and $150; therefore the median is $100.

To determine the UCR amount, consider the following example: If a plan generally pays 70% of the UCR amount for out-of-network services, the plan may charge 100% of the UCR amount reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency services were provided in-network.

Determining a plan's coverage requirement for out-of-network emergency services is perhaps best illustrated by example:

Example. A group health plan provides coverage for out-of-network emergency services. The plan has agreements with in-network providers for certain emergency services in the following amounts: one has agreed to accept $85, two have agreed to accept $100, two have agreed to accept $110, three have agreed to accept $120, and one has agreed to accept $150. Under the agreement, the plan agrees to pay the providers 80% of the agreed amount, with the participant responsible for the remaining 20%. In this example, the median is $110; therefore, the amount calculated under the first bullet above is 80% of $110 ($88). In this example, the participant receives care from one of the out-of-network providers that charges $120.

With respect to the second bullet above, the plan generally reimburses participants for 50% of the UCR amount (for purposes of this example, the UCR amount is $116). Subtracting the 20% in-network coinsurance from $116 leaves $92.80. With respect to the third bullet above, the Medicare payment is $80. In this example, the greatest amount is $92.80; therefore, the participant is responsible for the difference between the $120 charged and the $92.80 paid by the plan ($27.20).

Conclusion

We expect additional guidance to follow and will keep our friends and clients informed. In the meantime, please feel free to contact your Proskauer attorney or any member of our Health Care Reform Task Force should you have questions regarding this Alert or any other aspect of health care reform.

[1] The “Affordable Care Act” means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA). For more information about the Act, please visit our Health Care Reform Task Force website at http://www.proskauer.com/practices/health-reform-task-force.
[2] Health Insurance Portability and Account Act of 1996, Public Law 104-191.

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