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Health Care Reform Management Alert Series

Issue 7

New Interim Rules Issued for Preexisiting Condition Exclusions, Lifetime and Annual Limits, Coverage Rescissions, and Patient Protections

This is the seventh issue in our series of alerts for employers on selected topics in health care reform. (Our general summary of health care reform and other issues in this series can be accessed by clicking here.) This series of Health Care Reform Management Alerts is designed to provide a more in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Patient Protection and Affordable Care Act (PPACA), as modified by the Health Care and Education Reconciliation Act of 2010 (HCERA) (collectively the "Act"), requires all group health plans to comply with certain mandates. This issue focuses on the Act's provisions related to preexisting condition exclusions, annual and lifetime limits, rescissions and certain patient protections. The Department of the Treasury, the Department of Labor and the Department of Health and Human Services ("HHS") — the three agencies responsible for implementing the Act's provisions related to group health plans — jointly issued Interim Final Rules ("the Rules") related to these provisions, which are published in today's Federal Register (click here for a copy of the Rules). Most of the changes discussed in these Rules become effective January 1, 2011, for calendar year plans.

No Preexisting Condition Exclusions

Under the Act, group health plans ("plans") and health insurance issuers ("issuers") may not impose preexisting condition exclusions, regardless of whether an individual has prior creditable coverage. This prohibition on preexisting condition exclusions is generally effective for plan years beginning on or after January 1, 2014. However, for individuals under the age of 19, this rule becomes effective for plan years beginning on or after September 23, 2010. This requirement applies to grandfathered plans as well.

The guidance makes clear that any exclusions based on *when* a condition or injury occurred are impermissible. For example, a plan that excludes benefits for orthopedic surgery — if the surgery is required due to a traumatic injury that occurred before the effective date of coverage — is not in compliance with the Act. This is because the specific exclusion of orthopedic surgery effectively excludes benefits for a condition (i.e., the traumatic injury) based on the fact that the condition was present before the effective date of coverage. This guidance does confirm, however, that plans may still exclude benefits for a condition altogether as long as the exclusion applies regardless of when the condition arose.

No Lifetime or Annual Limits on Essential Health Benefits

Lifetime Limits. Plans and issuers are prohibited from applying lifetime dollar limits on "essential health benefits" under the Act. This ban on lifetime limits applies to all plans, regardless of grandfathered status, for plan years beginning on or after September 23, 2010.

Annual Limits. Similarly, plans and issuers are prohibited from applying annual dollar limits on "essential health benefits," effective for plans years beginning on or after January 1, 2014. This rule applies to all plans, regardless of grandfathered status.

A plan or issuer may impose annual limits on essential health benefits for plan years beginning before January 1, 2014, but only if the dollar amount is no less than the amount reflected in the following schedule:

Plan Year	Annual Limit Not Less Than
Plan year beginning on or after 9/23/10, but before 9/23/11 *(2011 for calendar year plans)*	$750,000
Plan year beginning on or after 9/23/11, but before 9/23/12 *(2012 for calendar year plans)*	$1,250,000
Plan years beginning on or after 9/23/12, but before 1/1/14 *(2013 for calendar year plans)*	$2,000,000

Plans and issuers may impose annual limits on essential benefits that are higher than those reflected in the schedule above. For example, a calendar year plan may impose an annual limit of $800,000 on an essential health benefit for the 2011 plan year. The Rules make it clear that these minimum annual limits apply on an individual-by-individual basis. A plan cannot use an overall annual dollar limit for families to deny a covered individual the minimum annual benefits for the plan year.

What are Essential Health Benefits?

These Rules refer to the definition of "essential health benefits" provided in the Act itself, but note that additional guidance may expand upon this list. The Act provides that "essential health benefits" are:

- 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
- preventative and wellness services and chronic disease management
- pediatric services, including oral and vision care

Until Rules are issued further defining "essential health benefits," plans may use good faith efforts and a reasonable and consistent interpretation of the term.

Notably, plans and issuers may still retain lifetime and annual dollar limits on benefits that are not "essential health benefits" as long as otherwise permitted under federal or state law. At least under the current guidance, plans may also exclude all benefits for a particular condition, including an essential health benefit. If the plan provides any benefit for a condition, however, these rules apply. This means that if a plan chooses to offer an essential health benefit, it cannot place a limit on those benefits (subject to the restricted annual limits, discussed above).

Special Enrollment. The Rules require plans and issuers to offer a special enrollment right to individuals who were previously ineligible for benefits because of a lifetime limit that may no longer be applied. The plan or issuer must give the individual notice of this special enrollment right and at least a 30-day window in which to enroll in the coverage. The enrollment opportunity and notice must be provided no later than the first day of the plan year beginning on or after September 23, 2010, and coverage must be effective as of that first day of the plan year. Any individual who enrolls during this special enrollment period must be offered all the benefit packages available to similarly situated individuals (which means participants must be allowed to newly elect to participate in the plan or to switch benefit options), and cannot be charged more for this coverage than similarly situated individuals. This special enrollment notice may be included in open enrollment materials as long as the information is prominently displayed.

Other Provisions. The Rules indicate HHS will establish a waiver program for plans and issuers to avoid complying with the new "restricted annual limit" rules if compliance with these rules would result in a significant decrease in access to benefits or a significant increase in premiums (which may be the case for limited benefit plans, such as "mini-med" plans). The Rules also explain that the restrictions on annual limits do not apply to flexible spending arrangements (because they are subject to a $2,500 limit beginning in 2013 under the Act), medical savings accounts, or health savings accounts. Health reimbursement arrangements are not subject to these annual limit restrictions either, when they are integrated with other coverage as part of a group health plan that otherwise complies with these annual dollar limit rules. Retiree-only health reimbursement arrangements are also not subject to these annual limit restrictions. Because the agencies have requested comments on whether these rules should apply to stand-alone health reimbursement arrangements for active employees, it is currently unclear exactly how the annual limit restrictions will apply to these arrangements.

Prohibition on Rescissions of Coverage

Before the Act was adopted, plans or issuers could have rescinded coverage due to a misrepresentation of material fact, even if it was unintentional. The Act provides that plans and issuers may not rescind coverage once a participant has become covered, unless the individual's act, practice, or omission constitutes fraud, or the individual has made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. Under the Rules, an inadvertent misrepresentation of material fact is not enough to justify the rescission of coverage. This standard applies to all rescissions, whether in the group or individual insurance market and whether insured or self-insured. This prohibition on rescissions of coverage is effective for plan years beginning on or after September 23, 2010, even for grandfathered plans.

The Rules clarify that while a plan cannot rescind a participant's coverage unless there was fraud or an intentional misrepresentation of material fact, a plan may cancel coverage prospectively where a participant is no longer eligible under the terms of the plan. For example, if a participant drops to part-time status, and thus is no longer eligible for coverage, but the plan does not discover the participant's ineligibility for months, under the Rules, the plan may not rescind the individual's coverage effective *retroactively* as of the date the participant lost eligibility unless there is fraud or material misrepresentation. However, the plan is permitted, subject to other applicable federal or state laws, to cancel coverage prospectively.

The Rules also provide that if a rescission is legally permissible (for example, if the individual engaged in fraud), the plan or issuer must still provide a 30-day notice to the individual before coverage is rescinded. The agencies explain that this provision of the Rules is intended to give individuals and plan sponsors an opportunity to explore their rights to contest the rescission or look for alternate coverage.

Patient Protections

These provisions apply for plan years beginning on or after September 23, 2010, but only to new plans or plans that lose their grandfathered status. They do not apply to grandfathered plans.

Choice of Provider. The Act imposed various requirements on plans and issuers that have a network of providers. The Act requires that if the plan or issuer requires a designation of a primary care provider, it must permit a participant to designate any participating network primary care provider who is available to accept that individual. If a plan or issuer requires the designation of a participating primary provider for the child of a participant, then the plan must permit the designation of a physician who specializes in pediatrics to be the child's primary care provider (as long as the physician is an in-network provider). The Rules also prohibit a plan or issuer from requiring authorization or referral for a female participant to seek care from an in-network obstetrical or gynecological specialist. Under the Rules, summary plan descriptions and other similar descriptions of benefits must include a notice to individuals of these rights, and the Rules contain model language to meet this requirement.

Emergency Services. Under the Rules, if a plan or issuer provides any benefits for hospital emergency room services, it must not require any prior authorization (even if the services are provided at an out-of-network hospital). The Rules also prohibit any additional administrative requirements or limitations of benefits for out-of-network emergency services that are more restrictive than what applies to in-network providers for emergency services. The Rules specifically provide that any copayment amount or coinsurance rate for out-of-network emergency services cannot be greater than if the services were provided in-network. Any other cost-sharing requirements (such as a deductible or out-of-pocket maximums) can only be imposed for emergency services if the requirement applies generally to out-of-network benefits.

The Rules also permit out-of-network providers to balance bill patients for the difference between the provider's charge and the amount the provider receives from the plan or issuer and the patient's regular copayment or coinsurance amount. The Rules reflect the agencies' concerns that if a plan or issuer could pay an unreasonably low amount to providers, the patient protections provided under the Act could effectively be circumvented. To address this concern, the Rules state that it is necessary for plans and issuers to pay a "reasonable amount" to providers before a patient becomes responsible for the balance billing amount. The Rules provide different avenues for meeting this "reasonable amount" requirement, but generally provide the requirement is met if the plan or issuer provided benefits for out-of-network emergency services in an amount equal to the greater of three possible amounts:

1. *The amount negotiated with in-network providers for such services;*
2. *The amount calculated using the method the plan normally uses to determine out-of-network services (such as the usual, customary and reasonable charge), but applying the in-network cost-sharing provisions; or*
3. *The amount Medicare would pay for the service.*

Employer Action Plan

- Review plans for preexisting condition exclusions and remove them for children under 19.
- Review current lifetime and annual dollar limits in your plans and consider whether they apply to "essential health benefits." If so, remove the lifetime limits for such benefits, and make sure the annual limits meet with the applicable minimums ($750,000 for plan year beginning on or after September 23, 2010, but before September 23, 2011).
- Identify individuals who have become ineligible due to annual or lifetime limits under the plans and determine whether they are still eligible to participate. Provide at least a 30-day special enrollment period for these individuals to enroll in the plan or change benefit option elections.
- Review rescission provisions and revise plan documents and administrative practices to comply with new requirements (including 30-day advance notice for permissible rescissions).
- Add disclosure to SPDs and other plan description information (such as open enrollment materials) based on the model notice regarding selecting primary care providers, if applicable.
- For non-grandfathered plans, review your emergency services provisions and change out-of-network rules if necessary.

For further details, or if you have any questions regarding the requirements for the upcoming plan year, contact your Seyfarth Shaw LLP attorney or any Employee Benefits attorney listed on the website at www.seyfarth.com/employeebenefits, or send your questions to HealthReform@seyfarth.com.