



Regulations Issued on Pre-existing Condition Exclusions, Limits, Rescissions, Patient Protections

July 6, 2010

The IRS, DOL, and HHS have jointly issued interim final regulations implementing the health care reform rules for group health plans and health insurance coverage in the group and individual markets regarding preexisting condition exclusions (PCEs), lifetime and annual dollar limits on benefits, rescissions, and certain patient protections. The regulations generally apply to group health plans and insurers for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar-year plans). Highlights include:

==> **Prohibition of PCEs.** Group health plans and insurers are prohibited from imposing PCEs for plan years beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, the effective date is plan years beginning on or after September 23, 2010. The regulations revise the definition of PCE to include a denial of coverage, and the preamble makes it clear that for enrollees under age 19, this prohibition includes both denial of enrollment and denial of specific benefits based on a preexisting condition.

Although there is an earlier effective date for enrollees under age 19, existing HIPAA restrictions on preexisting condition exclusions continue to apply with respect to other enrollees until plan years beginning on or after January 1, 2014, when the complete prohibition kicks in.

==> **Lifetime and Annual Limits.** Lifetime limits on "essential health benefits" are prohibited, and annual limits on those benefits are first restricted and then prohibited. The regulations clarify that an exclusion of all benefits for a condition is not considered to be a lifetime or annual dollar limit. However, if any benefits are provided for a condition, then the annual and lifetime prohibitions apply.

-- What Are "Essential Health Benefits"? The regulations define "essential health benefits" by cross-reference to the definition in the statute and applicable (but not yet issued) regulations. For purposes of enforcement, until such regulations are issued, the agencies will take into account good faith efforts to comply with a reasonable interpretation of this term.

-- "Restricted Annual Limits" - For plan years beginning before January 1, 2014, the regulations permit "restricted annual limits" with respect to essential health benefits. A three-year phased approach for restricted annual limits is adopted, under which the annual dollar limits may be no less than the following:

(1) \$750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011;

- (2) \$1.25 million for plan years beginning on or after September 23, 2011 but before September 23, 2012; and
- (3) \$2 million for plan years beginning on or after September 23, 2012 but before January 1, 2014.

These minimum annual limits apply on an individual-by-individual basis (i.e., any overall annual dollar limit applied to families may not operate to deny a covered individual the minimum annual essential health benefits for the plan year). The regulations also allow HHS to establish a program under which the requirements relating to restricted annual limits may be waived if compliance would result in a significant decrease in access to benefits or a significant increase in premiums.

These restrictions do not apply to FSAs, HSAs, and Archer MSAs. The rule for HRAs varies depending on the type of arrangement. HRAs that are integrated with other coverage (as part of a larger group health plan) are not subject to the annual limit restrictions, so long as the other coverage complies with lifetime and annual limit requirements. Retiree-only HRAs are also not subject to annual limits. The agencies have requested comments regarding the application of annual limit restrictions to stand-alone HRAs that are not retiree-only plans

-- Transitional Rules for Individuals Who Previously Reached a Lifetime Limit. Individuals who reached a lifetime limit under a group health plan or insurance coverage before the prohibition became effective and who are otherwise still eligible under the plan or coverage must be given a written notice that the lifetime limit no longer applies. If they are no longer enrolled, they must be provided a written notice (no later than the first day of the first plan year beginning on or after September 23, 2010) informing them of an enrollment opportunity that must continue for at least 30 days. The regulations provide details on this notice requirement, along with examples to help illustrate the rule. Individuals eligible for this enrollment opportunity must be treated as special enrollees (i.e., they must be given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment).

==> Prohibition on Rescissions. Group health plans and insurers may no longer rescind coverage except in a case of fraud or intentional misrepresentation of a material fact. Examples in the regulations illustrate this rule. The regulations also require that at least 30 calendar days' advance notice be provided to an individual before coverage may be rescinded. The regulations define rescission as a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuation of coverage that is prospective only, or one that is effective retroactively but is attributable to nonpayment of premiums or contributions is not a rescission.

==> Certain Patient Protections. The regulations implement the statutory provisions relating to choice of health care professionals and coverage of emergency services.

-- Choice of Health Care Professionals. If a plan or insurer requires a participant to designate a participating primary care provider from within the plan's network, it must permit the designation of any participating primary care provider who is available to accept the participant. Similarly, if the plan or insurer requires the designation of a pediatrician, it is required to permit the designation of any available physician (allopathic or osteopathic) within the network who specializes in pediatrics as the child's primary care provider. Plans or insurers that require designation of an in-network primary care provider may not require authorization or referral for a female participant who seeks covered obstetrical or gynecological care provided by an in-network health care professional who specializes in this field (not limited to a physician). Plans and insurers are required to provide notice to participants of these rights when applicable--the regulations contain model language and timing rules relating to this notice.

-- Coverage of Emergency Services. Plans or insurers that cover any emergency services in an emergency department of a hospital must do so:

- (1) without requiring prior authorization (even if the emergency services are provided out-of-network); and
- (2) regardless of whether the services are furnished by a participating provider.

Furthermore, plans or insurers with a network of emergency service providers may not impose administrative requirements or limitations on out-of-network emergency services that are more restrictive than those applied to in-network emergency services. For out-of-network emergency services, compliance is required with detailed cost-sharing requirements, and services must be provided without regard to any other term or condition of coverage (limited exceptions apply, such as exclusion of or coordination of benefits).

==> Applicability to Grandfathered Health Plans. The regulations reiterate that the requirements relating to PCEs, lifetime and annual limits, and rescissions apply to grandfathered group health plans (in certain cases, compliance is not required by grandfathered health plans that are individual health insurance coverage). The rules relating to patient protections, however, do not apply to grandfathered health plans.

These regulations are nicknamed the "new Patient Bill of Rights regulations" in the HHS fact sheet. The preamble indicates that more guidance on other health reform provisions is on the horizon (including guidance on the waiver program for annual limits, the new appeals process requirements, and any notice requirements for cancellations of coverage other than in the case of rescission).

For additional information, please click on the following link or contact your Lawley Benefits Consultant.

<http://www.dol.gov/ebsa/healthreform/>

http://www.healthreform.gov/newsroom/new_patients_bill_of_rights.html

<http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23983>

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