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Health Care Reform Alert

July 12, 2010

New Guidance Issued on Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions of Coverage and Patient Protections

On June 22, 2010, the Departments of Health and Human Services, Labor and Treasury jointly issued another set of interim final regulations. These latest regulations address the requirements under the Affordable Care Act (ACA) for pre-existing condition exclusions/ limitations, lifetime and annual dollar limits on benefits, prohibitions on rescission of coverage and patient protections.

Prohibition on Pre-Existing Condition Exclusions

The ACA and the newly issued regulations expand the existing HIPAA definitions and requirements. Under the regulations, a pre-existing condition "exclusion" is defined as a limitation or exclusion of coverage based on the fact that the condition was present before the effective date of coverage (or if coverage was denied, before the date of the denial), whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. This includes any exclusion or limitation based on information relating to an individual's health status, such as a condition identified on a pre-enrollment questionnaire, a physical examination or a review of medical records during the pre-enrollment period.

Unlike HIPAA, where a pre-existing limitation could be imposed for limited periods, under the ACA and these regulations, a group health plan or health insurer *may not impose any pre-existing condition exclusions or limitations*.

This prohibition applies to applicants and enrollees under the age of 19 as of the first day of the plan year beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans), and for all others on the first day of the plan year beginning on or after January 1, 2014. Grandfathered plans that are group health plans or group insurance plans must comply with this prohibition, but individual health insurance that is grandfathered does not. (**Click here** to view our previous Alerts on grandfathered plans).

Lifetime Limits on the Dollar Amount of Coverage

A group health plan or health insurer may not impose any lifetime limit on the dollar amount of "essential health benefits" that are provided, though such limitations may be placed on specific non-essential covered benefits. This rule does not prohibit a group health plan or health insurer from excluding all benefits for a specific condition (though the Americans with Disabilities Act (ADA) might).

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"Essential health benefits" are yet to be defined by the Secretary of HHS, but at a minimum shall include: (i) ambulatory patient services, (ii) emergency services, (iii) hospitalization, (iv) maternity and newborn care, (v) mental health and substance use disorder services, including behavioral health treatment, (vi) prescription drugs, (vii) rehabilitative and habilitative services and devices, (viii) laboratory services, (ix) preventive and wellness services and chronic disease management, and (x) pediatric services, including oral and vision care.

If an individual loses coverage under a plan or policy because he or she has reached a lifetime limit, and becomes eligible for benefits not subject to such a limit by reason of this prohibition, the group health plan or health insurer must provide the individual with written notice of his or her renewed eligibility for benefits, and that notice must be provided not later than the first day of the plan year beginning on or after September 23, 2010. Additionally, the coverage must take effect no later than that same date, and the person must be treated as eligible for any of the then available benefit options, and would re-enroll as a special enrollee.

This prohibition applies for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans), and it applies to grandfathered plans as of the same effective dates.

Annual Limits on the Dollar Amount of Coverage

For plan years beginning before January 1, 2014, a group health plan or health insurer may impose annual dollar limits on essential health benefits only as follows:

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, $750,000;
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, $1,200,000; and
- For a plan year beginning on or after September 23, 2012, but before January 1, 2014, $2,000,000.

For plan years beginning on or after January 1, 2014, annual limits on the dollar amount of benefits for essential health benefits for any individual are prohibited. Health care flexible spending accounts are, however, exempt from this prohibition. These annual limits apply on an individual-by-individual basis. Any annual limits on family coverage cannot operate to deny an individual benefits up to the annual dollar limit allowed by the plan. This limitation/prohibition applies for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans), and it applies to grandfathered plans as of the same effective date.

Note – both the lifetime and annual limits are designated as "dollar amount" limits. The regulations do not expressly address whether plans or policies may limit coverage by imposing non-monetary limits, such as the number of days or episodes of treatment.

Prohibition on Rescissions of Coverage

The regulations define rescission of coverage as any cancellation or discontinuance of coverage that has a retroactive effect. A rescission does not occur if the cancellation or discontinuance has only prospective effect, or if it is effective retroactively due solely to a failure to timely pay either premiums or required contributions.

Under existing law, in many jurisdictions, rescissions are permitted if the individual makes a material misrepresentation on an insurance or coverage application or claim. Under these regulations, rescissions are permissible only if the individual performs an act, practice or omission that constitutes fraud, or *intentionally* misrepresents a material fact.

A group health plan or health insurer must provide at least 30 days advance written notice before coverage may be rescinded.

These rules apply whether the coverage is insured or self-funded, or whether the rescission applies to an entire group or only to an individual within the group.

This limitation/prohibition applies for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans), and it applies to grandfathered plans as of the same effective dates.

Patient Protections

A. Designating Primary Care Providers - If a group health plan or health insurer requires or allows for a designation of a primary care provider, each participant or beneficiary must be allowed to designate any participating primary care provider available to accept the person as a patient. This requirement also applies to choosing a primary pediatric care physician as a child's primary care physician.

A group health plan or health insurer that requires participants and beneficiaries to designate primary care providers must notify them of this requirement and of their rights to (i) designate any available primary care provider and (ii) designate any available pediatrician as a child's primary care provider. Model notice language is provided in the regulations.

B. Obstetric and Gynecological Care - A group health plan or health insurer may not require a female participant or beneficiary to have authorization or a referral (including by a primary care physician) to obtain obstetrical or gynecological care, and must treat

the provision of obstetric or gynecological care and the ordering of related services by a health care professional specializing in those fields as the authorization of a primary care physician.

Nothing in the regulations is to be construed to (i) waive any exclusions of coverage under the terms of the plan or policy with respect to obstetric or gynecological care, and (ii) preclude any plan or insurer from requiring that the obstetrician or gynecologist notify the patient's primary care professional (if different) of any treatment decisions.

Female participants and beneficiaries must also be notified that the plan or insurer cannot require authorization or referrals for obstetric or gynecological care by a provider who specializes in those fields. This notice must be provided with or in any summary plan description (SPD) or similar description of benefits. Model notice language is provided in the regulations.

C. Emergency Services - A plan or insurer that covers emergency services must provide that coverage (i) without the need for any prior authorization, and (ii) without regard to whether the emergency services are provided in-network or out-of-network. If the emergency services are provided out-of-network, the limitation on coverage can be no more restrictive than those imposed on in-network emergency services, and any cost sharing requirements for out-of-network emergency services cannot exceed the cost sharing requirements for in-network emergency services.

To ensure that a plan or policy pays a "reasonable amount" for emergency services, a plan or policy will be treated as having met the cost sharing requirements if the plan or insurer provides emergency service benefits in an amount equal to the greatest of (i) the amount negotiated with in-network providers, (ii) the amount calculated using the same method the plan uses to determine payment for out-of-network services (such as the usual, customary and reasonable amount), excluding any in-network copayment or coinsurance, and (iii) the amount that would be paid under Medicare.

Any cost-sharing requirement, other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum), may be imposed on emergency services provided out-of-network if the same cost sharing requirement applies to in-network emergency service benefits.

Each of these requirements are effective for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans), but these requirements do not apply to grandfathered plans.

Action Steps

Employers who sponsor self-funded plans should review their administrative service agreements and any PPO contracts to which their plans may be a party to ensure that their current arrangements will meet these requirements in a timely fashion, or can be modified to do so. Employers who sponsor insured plans should consult with their insurers, HMOs or insurance agents/brokers to obtain the same assurances. Sponsors of either kind of plan must review their plan documents, SPDs, benefit schedules and other employee communications to ensure that they have been, or will be, timely amended to reflect these new requirements.

If you have any questions about these new prohibitions or requirements, or any other changes imposed by the ACA, please contact any of the Honigman attorneys listed on this Alert.