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Proposed Regulations Address Preexisting Condition Exclusions, Lifetime and Dollar Limits, Rescissions & Patient Protections Under the Health Care Act

As touted in the HealthReform.gov Fact Sheet, a major goal of the Patient Protection and Affordable Care Act (as amended by the Health Care and Education Reconciliation Act of 2010) (together, the "Act") is to put consumers back in charge of their health coverage and care. To that end, the Departments of Health and Human Services, Labor and the Treasury have released proposed regulations concerning the prohibition on preexisting condition exclusions, lifetime and annual dollar limits on benefits, restrictions on rescissions and patient protections.

Prohibition of Preexisting Condition Exclusions

The Act amends the HIPAA rules relating to preexisting exclusions and prohibits any preexisting condition exclusion from being imposed by *group* health plans and *group* health insurance coverage, and goes even further to extend this protection to *individual* health insurance coverage. Prior to the Act, the HIPAA rules applied only to group health plans and group health insurance coverage and permitted limited exclusions of coverage based on a preexisting condition under certain circumstances.

HIPAA generally defines a preexisting condition exclusion as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Based on this definition, the Act not only prohibits just an exclusion of coverage of specific benefits associated with a preexisting condition in the case of an enrollee, but also prohibits excluding the enrollee from the plan, if that exclusion is based on a preexisting condition. Note however that the proposed regulations did not change the HIPAA rule that an exclusion of benefits for a condition under a plan or policy is not a preexisting condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage.

The prohibition on preexisting condition exclusions is generally effective for plan years beginning on or after January 1, 2014. However, with respect to enrollees who are under age 19, the prohibition is effective for plan years beginning on or after September 23, 2010. Until the rules under the Act take effect, the HIPAA rules will continue to apply. A grandfathered health plan that is a group health plan or group health insurance coverage must comply with the Act's prohibition against preexisting condition exclusions; however, a grandfathered health plan that is individual health insurance coverage is not required to comply.

Lifetime and Annual Limits

The Act generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime or annual limits on the dollar value of essential health benefits. For plan years beginning before January 1, 2014, the proposed regulations allow "restricted" annual limits. For benefits that are not essential health benefits, a

plan or issuer may impose annual or lifetime per-individual dollar limits on specific covered benefits. The regulations define "essential health benefits" by cross-reference to an Act section and applicable regulations; however, such regulations have not yet been issued. Therefore, plans and issuers must make a good faith effort to measure their compliance with the regulations in this respect.

The regulations provide for a three-year phased implementation, which is intended to mitigate the potential for premium increases while at the same time ensuring access to essential health benefits. Under the regulations, annual limits on the dollar value of benefits that are essential health benefits may not be less than the following for plan years beginning before January 1, 2014:

- for plan years beginning on or after September 23, 2010 but before September 23, 2011 – $750,000;
- for plan years beginning on or after September 23, 2011 but before September 23, 2012 – $1.25 million; and
- for plan years beginning on or after September 23, 2012 but before January 1, 2014 – $2 million.

Note that the above limits are *minimum* limits. Plans or issuers may use higher annual limits or impose no limits. The minimum annual limits apply on an individual-by-individual basis. Thus, any overall annual dollar limit on benefits applied to families may not operate to deny a covered individual the minimum annual benefits for the plan year.

The regulations clarify that individuals who reached a lifetime limit under a plan or health insurance coverage prior to the applicability date of these regulations and are otherwise still eligible under the plan or health insurance coverage must be provided with a notice that the lifetime limit no longer applies. If such individuals are no longer enrolled in the plan or health insurance coverage, the regulations provide an enrollment (or in the individual market, reinstatement) opportunity for such individuals. The notice and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Anyone eligible for an enrollment opportunity must be treated as a special enrollee, meaning he or she must be given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

Note that the restriction on annual limits applies differently to certain account-based plans, especially where other rules apply to limit the benefits available. For example, the Act limits salary reduction contributions for health flexible spending arrangements ("health FSAs") to $2,500 per year beginning in 2013. The proposed regulations therefore provide that the annual limit rules do not apply to health FSAs.

The prohibition on lifetime limits applies to all group health plans and health insurance issuers offering group or individual health insurance coverage, whether or not the plan qualifies as a grandfathered health plan, for plan years beginning on or after September 23, 2010. The prohibition on annual limits, including the special rules regarding restricted annual limits for plan years beginning before January 1, 2014, applies to group health plans and group health insurance coverage, whether or not grandfathered, but do not apply to grandfathered health plans that are individual health insurance coverage.

Prohibition on Rescissions

A group health plan or a health insurance issuer offering group or individual health insurance coverage must not rescind coverage except in the case of fraud or an *intentional* misrepresentation of a material fact. The regulations define a rescission as a cancellation or discontinuance of

coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. A cancellation or discontinuation of coverage with only a prospective effect is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

The Act also added a new advance notice requirement when coverage is rescinded where still permissible. The regulations provide that a group health plan or a health insurance issuer offering group health insurance coverage must provide at least 30 days' advance notice to an individual before coverage may be rescinded. The notice must be provided regardless of whether the rescission is of group or individual coverage, or whether, in the case of group coverage, the coverage is insured or self-funded, or the rescission applies to an entire group or only to an individual within the group. The 30-day period will provide individuals and plan sponsors with an opportunity to explore their rights to contest the rescission or look for alternative coverage. Future guidance on cancellation of coverage other than in the case of rescission is expected.

The rules regarding rescissions and advance notice apply to all plans, whether or not grandfathered, effective for plan years beginning on or after September 23, 2010.

Patient Protections

Choice of Health Care Professional. Individuals enrolled in a plan or health insurance coverage must be notified of their rights to:

- choose a primary care provider or pediatrician when a plan or issuer requires designation of a primary care physician; and
- obtain obstetrical or gynecological care without prior authorization.

With regard to an individual's designation of a primary care provider, the plan or issuer must permit each participant, beneficiary or enrollee to designate any participating primary care provider who is available to accept such individual. The regulations require plans and issuers to provide a notice to participants of these rights when applicable and provide model language for such notice.

Emergency Services. If a plan or health insurance coverage provides any benefits with respect to emergency services in an emergency department of a hospital, the plan or health insurance coverage must do so without requiring prior authorization and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services. The emergency services must be provided without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, a permitted waiting period or applicable cost-sharing requirements. The plan or issuer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.

In addition, cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirements imposed for in-network emergency services. Out-of-network providers however may balance bill patients for the difference between the providers' charges and the amount collected from the plan or issuer and from the patient in the form of a copayment or coinsurance amount, provided that a reasonable amount is paid for the services by the plan or issuer. In establishing the reasonable amount that must be paid, the regulations consider three amounts – the in-network rate; the out-of-network rate and the Medicare rate. Specifically, a plan or issuer satisfies the copayment and coinsurance limitations if it provides benefits for out-of-network emergency services in an amount equal to the greater of:

- the amount negotiated with in-network providers for emergency services;
- the amount for the emergency services calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions; or
- the amount that would be paid under Medicare for the emergency services.

For plans and health insurance coverage under which there is no per-service amount negotiated with in-network providers, the first amount above is disregarded. Additionally, if a plan or issuer has more than one negotiated amount with in-network providers for a particular emergency service, the first amount above is the median of these amounts, treating the amount negotiated with each provider as a separate amount in determining the median.

Furthermore, the second amount above is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services. For example, if a plan generally pays 70% of the usual, customary and reasonable amount for out-of-network services, the second amount above for an emergency service is the total (100%) of the usual, customary and reasonable amount for the service, not reduced by the 30% coinsurance that would generally apply to out-of-network services. However, this amount can be reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network. Finally, any other cost-sharing requirements, such as a deductible or out-of-pocket maximum, may be imposed with respect to out-of-network emergency services only if the cost-sharing requirement generally applies to out-of-network benefits.

The rules regarding patient protections do not apply to grandfathered plans although other federal or state laws related to these patient protections may apply regardless of grandfathered status. The rules apply to non-grandfathered plans effective for plan years beginning on or after September 23, 2010.

If you have any questions about these proposed final rules or any other employee benefit matters, please contact a member of our Benefits Law Group.

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