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More Health Reform Guidance – on Preexisting Condition Exclusions, Dollar Limits, Rescissions and Patient Protections

The federal agencies responsible for implementing the health reform law have issued interim final regulations that provide guidance on the application of the new rules on preexisting condition exclusions, dollar limits, rescissions and patient protections. They refer to these provisions as being part of the "Patients' Bill of Rights" under the new law.

Background

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, includes provisions designed to ensure that individuals can obtain and keep their health coverage regardless of their health status or other factors. To accomplish these goals, the law includes prohibitions on preexisting condition exclusions and the imposition of annual and lifetime dollar limits on health benefits. The law also includes other consumer protections, such as giving individuals the right to designate a primary care provider and assuring access to emergency care.

The Departments of Health and Human Services, Labor and Treasury have now issued interim final regulations that provide guidance on these provisions of the new law. The rules regarding preexisting conditions exclusion, lifetime and annual dollar limits, and rescissions apply to all group health plans regardless of grandfather status. The "patient protection" provisions apply only to plans that do not qualify as grandfathered health plans.

The Interim Final Regulations

Preexisting Condition Exclusions

Most group health plans are subject to the portability rules of the Health Insurance Affordability and Accountability Act (HIPAA). These rules limit the circumstances under which plans may impose preexisting condition exclusions and require that any exclusionary period be offset by creditable coverage.

The health reform law provides that effective for plan years beginning on or after September 23, 2010, group health plans and insurers may not impose any preexisting condition exclusion on enrollees under age 19. An

exclusionary period that applies to an enrollee at the time the prohibition goes into effect must end. For example, if a child enrolled in October 2010 has a preexisting condition that is subject to a six-month exclusionary period, the exclusion must end on January 1, 2011 if the plan is operated on a calendar year basis.

Plans and insurers may continue to apply preexisting condition exclusions consistent with the HIPAA portability rules on enrollees age 19 and older until the 2014 plan year, at which time no preexisting condition exclusions will be permitted.

> ***BUCK COMMENT.*** *The regulations clarify that plans are prohibited from denying both enrollment in the plan as well as specific benefit coverage based on the existence of a preexisting condition. The HIPAA nondiscrimination rules already prohibit group health plans from denying coverage on the basis of a preexisting condition.*

Annual and Lifetime Dollar Limits

The new law prohibits lifetime dollar limits on "essential health benefits" for plan years beginning on or after September 23, 2010. Plans may impose "restricted" annual dollar limits on essential health benefits until the 2014 plan year. Beginning in 2014, even restricted annual dollar limits are not permitted.

> ***BUCK COMMENT.*** *Although not specifically addressed, it appears that these rules apply to both in-network and out-of-network benefits. Also not specifically addressed are annual and lifetime day and visit limits, which would still appear to be allowed (except for mental health and substance use disorder benefits).*

Essential Health Benefits. The rules regarding lifetime and annual dollar limits only apply to "essential health benefits" – plans may continue to impose lifetime dollar limits, etc. on benefits that are not "essential." The statutory language states that these benefits should include at a minimum –

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorders, 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.

The law requires HHS to ensure that the scope of essential health benefits is equal to the scope of benefits provided under a "typical" employer plan and requires the DOL to conduct a survey of employer-sponsored coverage to determine benefits typically covered by employers.

BUCK COMMENT. *"Essential health benefits" are the types of benefits that must be provided by coverage through the exchanges once they are established – they are not mandates for employer plans. Employer plans only have to be concerned about essential health benefits in connection with the lifetime and annual dollar limits. Many plans have lifetime or annual dollar limits on services such as infertility coverage, durable medical equipment, home health services and chiropractic services. The preamble notes that until regulations defining essential benefits are issued, the agencies will take into account a "good faith effort" to comply with a reasonable interpretation of the term.*

Restricted Annual Dollar Limits. There has been much speculation over the meaning of the provision in the health reform law indicating that "restricted" annual dollar limits would be allowed prior to 2014. The regulations provide the minimum annual dollar limit that may be imposed on essential health benefits until 2014 as follows –

- $750,000 for the plan year beginning on or after September 23, 2010 but before September 23, 2011
- $1,250,000 for the plan year beginning on or after September 23, 2011 but before September 23, 2012
- $2,000,000 for the plan year beginning on or after September 23, 2012 but before January 1, 2014. (No annual dollar limit is permitted for plan years beginning on or after January 1, 2014.)

The regulations allow a plan to reduce an annual dollar limit as long as the dollar limit exceeds the applicable threshold, although it could lose its grandfather status. A plan may also "convert" a lifetime limit to an annual limit, in which case it will retain its grandfather status. (See our June 23, 2010 *For Your Information*.)

Impact on Limited Benefit Plans. The regulations specifically address plans that have annual limits below the permissible restricted annual limits, such as "mini-med" plans. The agencies note that for plan years beginning before 2014, HHS will establish a waiver program to allow these plans to continue without meeting the minimums outlined in the regulations. Plans wishing to take advantage of the waiver will have to show that compliance with the minimum annual limits would either significantly decrease access to benefits or would cause a significant increase in the premiums for the benefit coverage. Details about the program are expected in separate guidance.

BUCK COMMENT. *The waiver program shows that the agencies recognize that requiring employers to significantly increase annual limits in these plans could cause them to either drop them entirely or to significantly raise premiums. Either of these actions would result in fewer people having coverage prior to 2014. Depending on the details, the waiver program may allow limited plans to continue for the next few years.*

Application of Annual Limits to Account Plans. The regulations exempt health flexible spending arrangements from the rules regarding annual dollar limits. The preamble to the regulations states that the rules do not apply to health savings accounts. The preamble also discusses the application of the rules to health reimbursement accounts (HRAs), stating that the rules do not apply to HRAs that only cover retirees nor do they apply to HRAs offered in conjunction with group health plan coverage as long as the underlying coverage complies with the rules regarding annual and lifetime dollar limits. The agencies are soliciting comments on the treatment of stand-alone HRAs that are not limited to retirees.

Notice of the Elimination of Lifetime Dollar Limits. In the past, some participants or beneficiaries may have reached their lifetime dollar limits under a particular plan, which may have prompted them to drop coverage. If these individuals are otherwise still eligible for coverage, they must be given notice that the lifetime limits no longer apply and that they have the right to re-enroll for benefits under the plan. Individuals who are still enrolled in the plan must be permitted to switch benefit options, if more than one option is available. These individuals cannot be charged more for coverage than other enrollees who did not previously exceed the plan's lifetime limit.

Individuals must be given a period of at least 30 days in which to enroll. The notices and enrollment opportunity must be provided before the first day of the plan year beginning on or after September 23, 2010, and coverage must be effective as of that date. Notices may be provided to employees on behalf of their dependents. The regulations indicate that these notices may be included with other open enrollment materials "provided the statement is prominent."

A model notice for this purpose has just been issued by the DOL.

> ***BUCK COMMENT.*** *As a practical matter, plan sponsors may wish to provide the notice as part of their regular open enrollment process, along with the similar required notice for adult child coverage (the DOL also issued a model notice for this purpose). However, they will have to make certain that employees who previously reached (or had a family member who reached) the lifetime limit and are currently not enrolled become aware that the limits have been removed and that they should consider reenrollment.*

Prohibition on Rescissions

The concept of rescission is usually associated with the individual insurance marketplace and involves a situation in which an insurer terminates the coverage of an individual retroactively after he or she has incurred large claims. To address this abuse, the health reform law prohibits both insurers and group health plans from rescinding coverage except in cases of fraud or intentional misrepresentation of material fact.

The regulations clarify that the term "rescission" is generally limited to retroactive terminations of coverage but does not include a retroactive termination for failure to pay premiums in a timely manner. Generally, rescissions are only permitted in the case of fraud or misrepresentation and individuals must be provided written notice at

least 30 days in advance of termination. A termination with prospective effect is not considered a rescission and may be permitted without proof of fraud or misrepresentation.

BUCK COMMENT. *Thus, plan sponsors conducting dependent audits may still drop ineligible dependents, but generally only on a prospective basis. It will likely be difficult to establish fraud in these situations.*

New Patient Protection Rules

The health reform law sets out certain requirements relating to choice of providers and emergency medical services, but none of these apply to grandfathered plans. For non-grandfathered plans, these rules are generally effective for plan years beginning on or after September 23, 2010. The requirements are similar to many state laws that apply to insurance carriers and HMOs.

Choice of Provider Rules. Three separate rules apply to plans which utilize a network of providers –

- If a plan requires or provides for the designation of a primary care provider (PCP), it must allow a participant to designate any participating PCP who is available to accept the patient. The plan is allowed to designate a PCP for a participant who enrolls without choosing a PCP.
- For a child, the plan must allow a participating pediatrician to be designated as the PCP.
- A plan cannot require any preauthorization or referral to access an OB/GYN provider. If a participant sees a participating OB/GYN provider, the plan must treat the care (and ordering of related services) as though it were provided by the PCP.

BUCK COMMENT. *Thus, a non-grandfathered plan can only impose authorization or other requirements for care delivered by an OB/GYN provider if these requirements would also apply to similar care received from a PCP.*

Choice of Provider Model Notice. Non-grandfathered plans must notify participants of the choice of provider rules whenever the plan or issuer provides a participant with an SPD or other similar description of benefits. The regulations provide model language for this purpose, which has also been released separately by the DOL.

BUCK COMMENT. *Interestingly, the recent release of model language from the DOL included a requirement that these notices be distributed no later than the first plan year following September 23, 2010. Even if SPDs are not being distributed at this time, plan sponsors of non-grandfathered plans (including those not subject to ERISA) should consider inserting the model language in open enrollment materials.*

Coverage of Emergency Services. The law prohibits non-grandfathered group health plans from requiring prior approval for emergency care whether in-network or out-of-network. The regulations define emergency with reference to the standards set out in the Emergency Medical Treatment and Labor Act (EMTALA), the law that prevents hospitals from transferring women in active labor and others facing emergency conditions.

The regulations indicate that reductions in cost-sharing may be allowed for patients who notify the plan of an emergency room (ER) visit, but plans cannot require pre-authorization in exchange for reduced out-of-pocket costs.

Generally, if a plan provides any benefits with respect to emergency services in the ER of a hospital, then the plan must –

- cover such services without requiring prior authorization (in-network or out-of-network)
- cover such services without regard to whether the health care provider is an in-network provider
- not impose any administrative requirements or limitations that are more restrictive for out-of-network than for in-network
- not impose out-of-network copays or coinsurance requirements that exceed in-network levels, although a plan can impose an out-of-network deductible or maximum if these generally apply to out-of-network benefits (not just emergency care). Further, providers will be allowed to balance bill.

For out-of-network providers, plans will meet these new rules by paying an amount equal to the greatest of the following –

- the amount negotiated with in-network providers (note that if network providers have negotiated different rates, this number will be the median of all those rates)
- the amount calculated under its normal out-of-network method (such as usual, customary and reasonable) but substituting the in-network cost-sharing provisions
- the amount Medicare would have paid.

If in-network providers are paid on a capitation basis, the first item above is ignored and the plan must pay out-of-network providers based on the greater of the second two items.

Conclusion

These regulations represent just a small part of the guidance needed to implement the new health care reform requirements. It is hoped that additional guidance will come quickly, as plan sponsors gear up for open enrollment.

Buck's consultants would be pleased to discuss this latest guidance with you or any other issues you have in connection with the new health reform law.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.