Interim Final Rules on Preexisting Condition, Lifetime & Annual Limits, Rescissions and other Patient Protections

Written by Thomas Barker

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On June 22, 2010, the Departments of the Treasury, Labor, and Health and Human Services issued interim final regulations implementing the rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Patient Protection and Affordable Care Act regarding preexisting condition exclusion, lifetime and annual dollar limits on benefits, rescissions, and patient protections. These interim final regulations are effective 60 days after publication in the Federal Register. Comments are due on or before 60 days after publication.

Preexisting Condition Exclusions

Background

The Patient Protection and Affordable Care Act (PPACA) prohibits any preexisting condition exclusion from being imposed by group health plans or group health insurance coverage and extends this protection to individual health insurance coverage. This prohibition is effective for new and grandfathered group plans beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition becomes effective for plan years beginning on or after September 23, 2010.

- "Preexisting condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage):
  - Based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.
  - As a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.
- Preexisting condition exclusion prohibits not just an exclusion of coverage of specific benefits associated with a preexisting condition in the case of an enrollee, but also a complete exclusion from such plan or coverage, if that exclusion is based on a preexisting condition.
- The interim final regulations do 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.

Lifetime and Annual Limits

Background

The PPACA prohibits lifetime limits, and generally annual limits, on the dollar value of health benefits from being imposed by group health plans, group health insurance coverage, and individual health insurance coverage on "essential health benefits." Lifetime limits are prohibited for all plans – both new and grandfathered – for plan years on or after September 23, 2010. Annual limits are prohibited for new plans and grandfathered group plans beginning on or after January 1, 2014. Prior to January 1, 2014, new and grandfathered group

plans may impose "restricted annual limits."

- A group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any lifetime limit, and generally, annual limit on the dollar amount of benefits for any individual. Plans are permitted to impose limits with respect to specific covered benefits that are not "essential health benefits" to the extent that such limits are permitted under Federal or State law.
- Regulations defining "essential health benefits" have not yet been issued. Until such regulations are issued, the Departments will take into account "good faith efforts" to comply with a "reasonable interpretation" of the term "essential health benefits." Plans must apply the definition consistently.
- Prior to 2014, new and grandfathered group plans may impose the following "restricted annual limits":
    - 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, 250,000.
    - For a plan year beginning on or after September 23, 2012, but before January 1, 2014 - $2,000,000.
- Waiver Authority
    - Prior to January 1, 2014, the Secretary of Health & Human Services may establish a program under which the restricted annual limits are waived for a plan if compliance would result in a "significant decrease in access to benefits under the plan or health insurance coverage" or would "significantly increase premiums for the plan or health insurance coverage."
    - The regulations specifically mention coverage under a limited benefit plan or so-called "mini-med" plan.
- Notice & Enrollment Opportunity
    - Eligible individuals: Individuals whose coverage or benefits ended by reason of reaching a lifetime limit, and who become eligible (or are required to become eligible) for benefits not subject to lifetime limits under the PPACA.
    - Plans are required to provide notice to eligible individuals that lifetime limits no longer apply, and that they are once again eligible for benefits under the plan.
    - If such individuals are no longer enrolled in the plan, plans must provide an enrollment opportunity for 30 days for benefit packages available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit. Any difference in benefits or cost-sharing requirements constitutes a different benefit package.
    - For group health plans, notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is "prominent."
- The rules do not prevent a plan from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements on lifetime and annual limits apply. Other requirements of Federal or State law may require coverage of certain benefits.
- Annual limit rules do not apply to flexible spending arrangements (FSAs), Medical Savings Accounts (MSAs), and Health Savings Accounts (HSAs).
- Health Reimbursement Arrangements (HRAs)
    - When HRAs are integrated with other coverage as part of a group health plan, and the other coverage complies with the restrictions on lifetime and annual limits, the fact that benefits under the HRA by itself are limited does not violate the PPACA.
    - Stand-alone HRAs limited to retirees are generally not subject to the rules relating to annual limits.

Rescissions

Background

Under the PPACA, 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. This provision is effective for all plans – new and grandfathered – for plan years beginning on or after September 23, 2010.

- A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuation of coverage is not a rescission if it only has a prospective effect, or the retroactive effect is attributable to a failure to timely pay required premiums or contributions.
- Under prior law, rescissions may have been permissible if an individual made a misrepresentation of a material fact, even if the misrepresentation was not intentional or made knowingly. Under the new standard, plans and issuers cannot rescind coverage unless an individual was involved in fraud or intentional misrepresentation.
- Plans must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group.
- If the Departments become aware of attempts in the marketplace to subvert the rules regarding rescissions (for example, long, complex enrollment questionnaires), the Departments may issue additional regulations or administrative guidance to ensure individuals do not lose health coverage unjustly or without due process.

Patient Protections: Choice of Health Care Professional & Emergency Services

Background

The PPACA imposes a set of three requirements relating to the choice of a health care professional and requirements relating to benefits for emergency services for group and individual health insurance coverage. The three requirements relating to the choice of health care professional apply only to a plan or health insurance coverage with a network of providers. All requirements apply to new health plans beginning on or after September 23, 2010.

- Health Care Professional: If a plan requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider or pediatrician, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate such provider who is available to accept the participant, beneficiary, or enrollee.
- Obstetrical or Gynecological Care: Plans may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.
- "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in "serious jeopardy"; "serious impairment to bodily functions"; or "serious dysfunction of any bodily organ or part."
- "Emergency services" means a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.
- Prior authorization is not permitted for emergency services, and emergency services provided out-of-network should generally be treated similar to services provide in-network.
- Cost-Sharing
    - Any cost-sharing requirement for out-of-network emergency services cannot exceed the cost-sharing requirements for services provided in-network.
    - However, beneficiaries may be required to pay, in addition to in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under the rules.
    - Further, any cost sharing other than a copayment or coinsurance requirement may be imposed for out-of-network emergency services if the cost-sharing requirement applies to out-of-network benefits generally.

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