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Client Alert

HEALTH CARE REFORM LEGISLATION GUIDANCE ISSUED ON PREEXISTING CONDITION EXCLUSIONS, LIFETIME AND ANNUAL LIMITS, RESCISSIONS, AND PATIENT PROTECTIONS

July 8, 2010

The Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services issued another set of interim final rules for group health plans and health insurance coverage in the individual and group markets under the recent health care legislation (the "Rule"). The Rule sets forth the requirements for complying with the preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protections under the legislation. Most provisions of the Rule are effective for the first policy year beginning on or after September 23, 2010, with certain exceptions noted below. The following is an overview of some of the highlights of the Rule that are of particular importance to those who sponsor group health plans or offer health insurance coverage.

The Patient Protection and Affordable Care Act (the "Affordable Care Act"), Pub. L. 111-148, was enacted on March 23, 2010. A separate law, the Health Care and Education Reconciliation Act of 2010 (the "Reconciliation Act"), Pub. L. 111-152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act (collectively, the "Reform Acts") made sweeping changes to the current health care system that will become effective over the next several years. In June, the IRS, the DOL, and HHS issued interim final rules for group health plans relating to their status as a grandfathered health plan. You can read our previous alert on that guidance here. The most recent guidance discussed below, also issued by all three agencies, was issued on June 22, 2010.

PREEXISTING CONDITION EXCLUSIONS

Currently, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") limits the ability of a group health plan to exclude coverage for preexisting conditions. In most cases, HIPAA limits the preexisting condition exclusion period to 12 months (18 months if the participant is a late enrollee). This period is offset by a period of any prior health insurance coverage, as long as the participant did not have a break in coverage for longer than 63 days.

The Rule provides that a group health plan or health insurance coverage, including a grandfathered plan, may not impose a preexisting condition exclusion. This provision is generally effective for plan years beginning on or after January 1, 2014, however it is effective for plan years beginning on or after September 23, 2010 for enrollees under 19 years of age. Until this provision becomes effective, the existing HIPAA rules regarding preexisting conditions continue to apply for enrollees older than 18 years of age.

The Rule confirms that the definition of a preexisting condition exclusion is the same under the Reform Acts as under HIPAA. Thus, a preexisting condition is 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 the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before this date. This definition prohibits both exclusion of coverage for a particular condition and a complete denial of coverage.

LIFETIME AND ANNUAL LIMITS

Effective for plan years beginning on or after September 23, 2010, the Rule prohibits a group health plan or health insurance coverage, including a grandfathered plan, from establishing a lifetime or annual limit on the dollar amount of benefits for an individual. This provision does not apply to Health Flexible Spending Accounts ("FSAs"), nor to Health Savings Accounts ("HSAs") associated with high deductible health plans and it does not prevent a plan from excluding all benefits for a particular condition.

For plan years beginning before January 1, 2014, a group health plan or health insurance coverage, including grandfathered plans that are not individual health insurance policies, may impose an annual or lifetime dollar limit with respect to benefits that are essential health benefits, but the annual limit may not be less than:

- $750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011
- $1,250,000 for plan years beginning on or after September 23, 2011 but before September 23, 2012
- $2,000,000 for plan years beginning on or after September 23, 2012 but before January 1, 2014

The term "essential health benefits" is defined in Section 1302 of the Act and includes at a minimum, items and services in the following categories: ambulatory patient services; emergency services; hospitalization, maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Participants or beneficiaries who have already reached the lifetime limit under a plan have most likely dropped their health insurance coverage. These individuals must be provided with a notice that the lifetime limit on the dollar value of benefits no longer applies and that they are once again eligible for benefits under the plan, assuming they are still otherwise eligible for coverage. 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. The DOL has released a model notice that may be used to fulfill the notice requirement.

Program for "Mini-Medical"Plans. There was concern that mini-medical plans, which offer limited benefits, would be completely eliminated from the marketplace if the provisions of the

Reform Acts, in particular, the annual limit restrictions, were applied to them. However, the Rule provides that for plan years beginning before January 1, 2014, the Secretary of HHS may establish a program under which the minimum annual limit requirement will be waived if applying such limits would result in a significant decrease in access to benefits under the plan or would significantly increase premiums. Guidance regarding the scope and process for applying for the waiver is expected from HHS in the near future.

PROHIBITIONS ON RESCISSIONS

Effective for plan years beginning on or after September 23, 2010, a group health plan or health insurance coverage, including a grandfathered plan, may not rescind an individual's coverage once the individual becomes covered under the plan unless the individual performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact. If rescission of coverage is permissible, the plan or issuer must provide 30 days' notice before the rescission is effective. For purposes of the Rule, a rescission is a cancellation or discontinuance of coverage that is retroactive. A prospective cancellation, or a cancellation retroactive to the extent it is attributable to a failure to timely pay required premiums, is not prohibited by the Rule. Thus, it appears that the agencies are not taking the position that an employer cannot terminate coverage altogether after the plan year starting on or after September 23, 2010.

PATIENT PROTECTIONS

The Rule provides guidance on the patient protections provided by the Acts. Note that grandfathered plans are not required to provide these protections. However, for non-grandfathered plans, these rules are generally effective for plan years beginning on or after September 23, 2010.

Designation of primary care provider. If a group health plan or health insurance coverage requires designation of a primary care provider, the covered individual must be allowed to designate any participating primary care provider who will accept the individual. A plan or issuer must provide notice of the terms of the plan regarding the designation.

Designation of pediatrician as primary care provider. If a group health plan or health insurance coverage requires designation of a primary care provider for a covered child, the plan must allow designation of any participating pediatrician who will accept the child. A plan or issuer must provide notice of the terms of the plan regarding the designation.

Patient access to obstetrical and gynecological care. A group health plan or issuer of health insurance coverage may not require authorization or referral with respect to female participants seeking coverage for obstetrical and gynecological care from a participating health care professional that specializes in obstetrics or gynecology. The plan or issuer must notify participants that it may not require such authorization.

The DOL has released a Patient Protection Model Disclosure that may be used to fulfill the notice requirement applicable to the above protections.

COVERAGE OF EMERGENCY SERVICES

Effective for plan years beginning on or after September 23, 2010, the Acts prohibit non-grandfathered group health plans from requiring prior approval for emergency services. If a group health plan or health insurance coverage provides any benefits for emergency services, coverage must be provided:

- without the need for prior authorization, even if the services are provided on an out-of-network basis;
- without regard to whether the health care provider is a participating provider;
- for out-of-network services, without imposing limitations on coverage that are more restrictive than those provided for emergency services provided in-network; and
- without imposing a copayment or coinsurance rate for out-of-network services that exceeds the rate imposed for in-network services.

CONCLUSIONS

Since most of the provisions of the new Rule are effective for the first policy year beginning on or after September 23, 2010, and most provisions apply to plans regardless of whether they qualify as a grandfathered health plan, plan sponsors will have to quickly review their plans to determine if they comply with the provisions of the Rule.

Contact Information: If you have questions regarding the effect of the Rule and health care reform on your health plan, please contact Diane J. Fuchs or Elisa A. Cawood, the principal authors of the alert. You may also contact the Womble Carlyle attorney with whom you usually work, or one of our Employee Benefits attorneys.