McAfee & Taft

HEALTH CARE REFORM UPDATE

JULY 15, 2010

Additional 'Interim Final Regulations' issued

On June 22, 2010, the Departments of Health and Human Services, Labor and Treasury jointly issued additional interim, final regulations (the "Interim Final Regulations") concerning the legislative changes under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the "Reform Act"). These new regulations address the following issues: (i) pre-existing condition exclusions, (ii) annual and lifetime limits on benefits, (iii) rescissions of coverage, and (iv) patient protections. The following is a summary of the Interim Final Regulations.

Prohibition on Exclusions of Pre-existing Conditions

The Reform Act prohibits pre-existing condition exclusions from being imposed by a group health plan. The Interim Final Regulations provide guidance with respect to this prohibition by clarifying the definition of a pre-existing condition as follows:

- A pre-existing condition exclusion means a limitation or exclusion of benefits based on the fact that the condition was present before the effective date of coverage.
- A pre-existing condition exclusion includes not only an exclusion of benefits for the condition but also a denial of overall coverage under the plan.

The prohibition on pre-existing condition exclusions is applicable to plans effective for plan years beginning on or after January 1, 2014. However, the prohibition applies to individuals who are under 19 years of age for plan years that begin on or after September 23, 2010 (for calendar year plans this means January 1, 2010).

Prohibition on Lifetime and Annual Limits

The Reform Act also prohibits plans (and health insurers) from imposing annual or lifetime limits on the dollar value of "essential health benefits." The Interim Final Regulations clarify the obligations of health care plans with respect to the prohibition on annual and lifetime limits as follows:

1. **Individuals who previously reached a lifetime limit.** An individual who reached a lifetime limit prior to the first plan year beginning after September 23, 2010, and who is otherwise eligible for benefits under a plan is subject to the following:
   - The individual must be permitted to enroll in the plan as a special enrollee (i.e. the individual must be given the right to enroll in all available benefit packages).
   - The individual must be notified of the enrollment rights described above and that the lifetime limit no longer applies.

   The notice and enrollment opportunity must be provided not later than the first plan year beginning after September 23, 2010. The Department of Labor has provided a model notice regarding the special enrollment requirement.
2. **Essential Health Benefits.** For plan years beginning prior to January 1, 2014, a group health plan may impose annual or lifetime limits on benefits which are not "essential health benefits." The Interim Final Regulations do not define "essential health benefits" except to refer to the Reform Act and provide that plans must act consistently and in good faith. The Reform Act defines "essential health benefits" to include, at a minimum:
   - Ambulatory Patient Care
   - Emergency Services
   - Hospitalization
   - Maternity and newborn care
   - Mental health and substance abuse disorder services, including behavioral health treatment
   - Prescription drugs
   - Rehabilitation and habilitative services and devices
   - Laboratory services
   - Preventive and wellness services
   - Chronic disease management
   - Pediatric services including oral and vision care
3. **Condition–based exclusions.** The Interim Final Regulations do not prevent a plan from excluding all benefits for a particular condition.

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4. **Non-dollar value limitations.** Neither the Reform Act nor the Interim Final Regulations specifically address limitations on benefits which are not stated in terms of dollars. Such limitations could include, for example, a limit on the number of doctor visits permitted per year. However, the express language of both the Reform Act and the Interim Final Regulations refers to dollar limits. Therefore, it would appear that such non-dollar amount limitations would be permitted.

5. **Phase-in of annual limits.** For plan years beginning prior to January 1, 2014, a plan can apply the following annual limits:

For Plan Years beginning on or after:	And before:	Maximum annual limit is:
September 30, 2010	September 30, 2011	$ 750,000
September 30, 2011	September 30, 2012	$1,250,000
September 30, 2012	January 1, 2014	$2,000,000

In applying these limits:

- A grandfathered plan may not impose a limit if it did not previously have one or lower a limit without losing its grandfathered status.
- Only "essential health benefits" are taken into account in determining whether the limits are reached.

6. **Application to cafeteria plans.** Health flexible spending accounts under a cafeteria plan are not subject to the prohibition on annual or lifetime limits.

Prohibition on Rescissions

The Reform Act prohibits a plan from rescinding coverage with respect to an individual once the individual is covered under the plan unless coverage was obtained through fraud or intentional misrepresentation of a material fact. In addition, the Reform Act requires a plan to notify a participant in advance if coverage is to be rescinded. The Interim Final Regulations clarify that a rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it only has a prospective effect or if the cancellation or discontinuance is effective retroactively but is due to a failure to make the timely premium payment.

Patient Protection Concerning Choice of Healthcare Providers – These requirements do not apply to grandfathered plans

The Interim Final Regulations reiterate certain patient protections related to the choice of healthcare providers and emergency services. With respect to the choice of healthcare providers, the Reform Act and the Interim Final Regulations provide that a plan participant must be given the choice of selecting his or her primary healthcare provider from among a plan's network of providers. In addition, the Reform Act and the Interim Final Regulations (i) impose a requirement allowing for the designation of a pediatrician as a primary care physician for a child, and (ii) provide that a plan may not require authorization or referral by the plan or another primary care provider for a female participant who seeks obstetrical or gynecological care provided by an in-network health care professional.

The Reform Act and the Interim Final Regulations also provide that a non-grandfathered plan which provides benefits with respect to emergency room services may not require pre-authorization and must provide benefits with respect to emergency services without regard to whether the health care provider furnishing the emergency service is an in-network provider.

For additional information, please contact any member of **McAfee & Taft's Employee Benefits Practice Group**.

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