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Agencies Issue Regulations Under Patient Protection and Affordable Care Act

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On June 28, 2010, the U.S. Departments of Treasury, Labor, and Health and Human Services published interim final regulations under the Patient Protection and Affordable Care Act (PPACA) that provide guidance on exclusions for pre-existing conditions, lifetime and annual dollar limits, health plan rescissions, and patient protections. The interim final regulations are generally applicable for health plan years beginning on or after September 23, 2010.

Exclusions for Pre-existing Conditions In Children Under Age 19

The interim final regulations prohibit an insurance plan from denying coverage to children under the age of 19 on the basis of a pre-existing condition. This ban prohibits both benefit limitations (e.g., when an insurer or health plan refuses to pay for a specific treatment because the child had a pre-existing condition before enrollment) and outright coverage denials (e.g., when an insurer refuses to offer a policy to a family because of the child's pre-existing condition). This ban will apply to all types of insurance except individual policies that are "grandfathered."

Under the PPACA, by 2014, the ban on exclusions for a pre-existing condition will apply to individuals of all ages.

Annual and Lifetime Limits

The interim final regulations prohibit all health plans and policies issued on or after September 23, 2010, from imposing lifetime limits on coverage for essential health benefits. In addition, annual dollar limits are required to be phased out by 2014. In particular, for health plans or policies issued or renewed on or after September 23, 2010, the annual limits must be no less than $750,000. The minimum annual limit is raised to $1.25 million on September 23, 2011, and to $2 million on September 23, 2012. For health plans issued or renewed on or after January 1, 2014, annual limits on the coverage for essential health benefits are banned altogether. The interim final regulations clarify that the prohibitions against annual limits do not apply to flexible spending arrangements (FSAs), medical savings accounts

(MSAs), and health savings accounts (HSAs). The regulations also clarify that the prohibitions on lifetime and annual limits do not apply to health reimbursement accounts (HRAs) that are integrated with other health benefits where the other health benefits do violate the lifetime or annual limitation rules.

Patient Choice and Out-of-Network Emergency Care
The interim final regulations require health plans to allow participants to choose any available participating primary care provider as a primary provider and any available participating pediatrician as a child's primary provider. In addition, health plans or insurers and networks are prohibited from requiring participants to obtain a referral for obstetrical or gynecological care. Health plans or insurers also must inform participants that referrals are not required. The interim final regulations also prohibit health plans or insurers from charging higher copayments and coinsurance for out-of-network emergency care.

Rescissions
The regulations provide that health plans and insurance policies cannot be rescinded, except in the case of fraud or intentional misrepresentation by a covered individual. In instances of fraud or intentional misrepresentation, the interim final regulations state that the health plan or insurer must provide a notice of intent to rescind with at least 30 days advanced notice in which the covered individual may appeal the rescission.

The interim final regulations can be found at http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23983. Comments are due August 27, 2010.

ABOUT THE LAW FIRM:
The Amadeo Law Firm, PLLC, is a litigation and consultation boutique with offices in Frederick, MD & Washington, D.C. The firm represents clients in commercial, employment & employee benefit, and government contracting matters.

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