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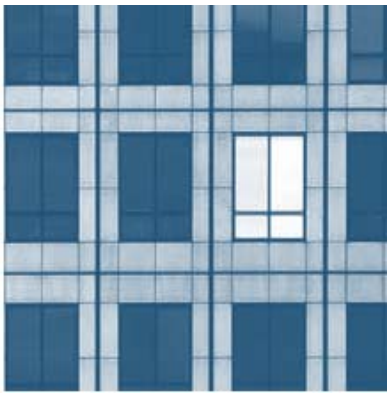
On the Subject



Health Industry Advisory

June 29, 2010

The U.S. Departments of Health and Human Services, Labor and the Treasury have issued interim final rules on pre-existing condition exclusions, lifetime and annual limits, rescission of coverage and patient protections.

Health Care Reform: PPACA Interim Final Regulations on Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

The U.S. Departments of Health and Human Services, Labor and the Treasury have issued interim final rules on four separate provisions of the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010. The interim final rules provide long-awaited guidance on the following provisions:

I. Pre-existing Condition Exclusions Prohibited

Effective for plan or policy years beginning on or after September 23, 2010, group health plans, whether grandfathered or not, are prohibited from imposing pre-existing condition exclusions on children under the age of 19. Effective January 1, 2014, the PPACA prohibits all group health plans from imposing any pre-existing condition exclusions. Under the rules, an individual cannot be excluded from coverage for a condition based on the fact that the condition was present prior to receiving the coverage. In addition, benefits cannot be limited because of a condition in existence prior to the effective date of coverage. This is true regardless of whether or not any medical advice, diagnosis, care or treatment was recommended or received prior to enrollment in the coverage. An individual also cannot be denied coverage as a result of information relating to an individual's health status before the effective date of coverage. For example, coverage could not be denied on the basis of a condition identified as a result of a pre-enrollment questionnaire or physical examination relating to the pre-enrollment period.

The PPACA does not change the current rule that a plan can exclude benefits for a specific condition regardless of when that condition arose. In addition, prior to 2014, the current Health Insurance Portability and Accountability Act (HIPAA) rules regarding pre-existing condition exclusions may still be imposed on plan participants age 19 and older.

II. Lifetime and Annual Limits Prohibited

The PPACA prohibits group health plans and group health insurance issuers from offering group coverage that imposes any lifetime or annual limits on the dollar value of health benefits for plan or policy years beginning on or after September 23, 2010. The lifetime limit prohibition is immediate, not phased in. The prohibition on annual dollar limits, however, is phased in through 2014 for "essential health benefits." This rule applies to both grandfathered and non-grandfathered plans.

The interim final rule clarifies that the PPACA does not prohibit a plan or issuer from excluding all benefits for a specific condition. Further, lifetime and annual limits are still generally permitted with respect to covered benefits to the extent the benefits are not "essential health benefits.

Future regulations will define the term "essential health benefits." For now, however, "essential health benefits" include at least the following general categories and items and services covered within these 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. For plan or policy years beginning before the issuance of regulations defining "essential health benefits," the departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" for purposes of enforcement.

The regulations provide for a three-year phased-in approach for annual dollar limits on "essential health benefits." Prior to 2014, the annual dollar limit for any individual cannot be less than the amounts set forth in the following schedule:

- For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit is $750,000.
- For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit is $1.25 million.
- For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit is $2 million.
- For a plan year beginning on or after January 1, 2014, the limit is $0.

The interim final regulations give the U.S. Secretary of Health and Human Services the authority to waive restricted annual limits if compliance would result in a significant decrease in access to benefits or a significant increase in premiums. The waiver program is an attempt to address the fact that traditional limited scope benefit plans (primarily for the benefit of part-time employees) will not satisfy the new PPACA rules on annual limits and may cease to be a viable option without the waiver program. The regulations also confirm that the prohibition on lifetime and annual limits does not apply to health care flexible spending account plans, or integrated or retiree-only health reimbursement arrangements.

For individuals whose coverage previously ended due to reaching a plan's lifetime limit, the plan must provide written notice of the lapse of the lifetime limits and that the individual is once again eligible for benefits. In the event an individual is eligible for benefits but no longer enrolled, the plan and the issuer must provide a 30-day opportunity to enroll and written notice of the enrollment opportunity. The written notice and the enrollment opportunity must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010. Such individuals must be offered all of the benefit packages available to, and cannot be required to pay more than, similarly situated individuals who did not lose coverage as a result of imposition of lifetime limits under the plan. The U.S. Department of Labor (DOL) has issued a model notice at http://www.dol.gov/ebsa/healthreform/ for this purpose.

III. Prohibition on Rescissions

Effective for plan or policy years beginning after September 23, 2010, the PPACA also prohibits group health plans and group health insurance issuers from rescinding coverage, except in the case of fraud or an intentional misrepresentation of a material fact. Inadvertent omissions or unintentional misrepresentations do not give rise to grounds for rescissions of coverage. The new standard applies to both grandfathered and non-grandfathered health plans.

A rescission is a cancellation or discontinuation of coverage that has a retroactive effect. If a plan or health insurance issuer wants to rescind coverage, written notice must be provided to the individual at least 30 days before the rescission.

The rescission standard under the PPACA establishes a floor for other health coverage rescission laws. All state laws, and any other federal laws, may only provide a standard that is at least as strict as the PPACA rescission standard. If a state rescission law, for example, is less favorable to an individual than the standard under the PPACA, then the state law has no effect.

IV. Patient Protections

Effective for plan or policy years beginning on or after September 23, 2010, the PPACA protects a patient's right to choose a health care professional and receive benefits for covered emergency services. The patient protections apply only to non-grandfathered health plans, however, other federal or state laws may also apply to grandfathered plans.

Plans and issuers that allow individuals to select an in-network primary care provider or pediatrician must permit an individual to select such a provider that is available to accept the individual. In addition, if coverage is provided for obstetrical or gynecological care, a plan or issuer cannot require authorization or referral for a female participant to seek care from an in-network specialist. As part of this requirement, the plan or issuer must inform participants of their rights whenever they provide a summary plan description or other similar description of benefits. The DOL has recently issued a model notice at http://www.dol.gov/ebsa/healthreform/ for this purpose.

In addition, patients have the right to receive benefits for emergency services without prior authorization, regardless of whether they are out-of-network. Cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network services cannot exceed the cost-sharing requirements imposed for in-network services. In order to avoid excessive balance billing, the regulations require plans and

issuers to pay a reasonable amount for benefits before a participant becomes responsible for the balance of the bill. Under the interim final regulations, a reasonable amount is the greatest of:

- The median amount negotiated with in-network providers
- The amount for the services calculated with the same methodology generally used to determine payments for out-of-network services, but using the in-network cost-sharing provisions
- The Medicare fee for the service amount

Next Steps

Employers and insurers should review their current health plan designs to ensure compliance with these interim final rules. Plans, policies, summary plan descriptions, certificates and contracts for health insurance should be amended by the effective date to provide for the new requirements

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