Health Care Reform ALERT
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JUNE 30, 2010

New Health Care Reform Regulations Address Pre-Existing Conditions, Lifetime and Annual Coverage Limits, Restrictions on Rescission, and Patient Protections

BY PATRICIA MORAN

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act") create a broad roster of new requirements and prohibitions affecting individual and group health insurance contracts and employer-sponsored group health plans. These include curbs on lifetime and annual limits, coverage of preventative care, and limitations on waiting periods, among many others. On June 22, 2010, the Internal Revenue Service, U.S. Department of Labor, and U.S. Department of Health and Human Services issued an interim final regulation (the "Regulation") interpreting the following provisions of the Act:

- Prohibition on Preexisting Condition Limitations (PHSA[1] §2704)
- Prohibition on Lifetime and Annual Limits (PHSA §2711)
- Prohibition on Rescission of Coverage (PHSA §2712)
- New Patient Protections (PHSA §2719A)

This Alert highlights some of the key provisions of the Regulation. (Note that we refer to "grandfathered" plans throughout this alert. For more information on grandfathered plans, please see our June 16, 2010 Alert.)

Prohibition on Preexisting Condition Limitations (PHSA §2704)

The Act prohibits any preexisting condition exclusion[2] from being imposed by group health plans or group or individual health insurance coverage.

- This prohibition generally is effective with respect to plan years beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition is effective for plan years beginning on or after September 23, 2010 (for calendar year plans, January 1, 2011).
- The Regulation makes clear that the prohibition applies not just to the exclusion of a specific benefit relating to a preexisting condition, but also to a complete exclusion from a plan or coverage based on a preexisting condition.

For further information regarding this or any issue related to Health Care Reform, please contact one of the professionals listed below or the Mintz Levin attorney who ordinarily handles your legal affairs.

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- Grandfathered group health plans must comply with this provision, with one limited exception: grandfathered individual health insurance coverage is not required to comply.

Practitioner's observation: This prohibition applies to "enrollees" under age 19. Thus, the provision picks up not only children and dependents of plan participants, but also young workers who may themselves be participants.

Prohibition on Lifetime and Annual Limits (PHSA §2711)

Effective for plan years beginning on or after September 23, 2010, the Act prohibits group health plans and group or individual health insurance issuers from imposing lifetime or annual limits on the dollar value of health benefits.

Effect on Account-Based Plans

The Regulation clarifies that PHSA §2711 does not apply to Flexible Spending Account plans, Medical Savings Plans, or Health Savings Accounts. Health Reimbursement Account (HRA) plans coupled with other coverage will not violate PHSA §2711, so long as the other coverage does not violate §2711. A stand-alone retiree-only HRA will not violate PHSA §2711, but the fate of stand-alone HRA plans covering active participants is not yet settled (the regulators have asked for comments on this item).

"Essential Health Benefits"

The Regulation makes clear that a plan or issuer may impose annual or lifetime per-individual dollar limits on specific covered benefits that are not "essential health benefits." [3] The Act also allows "restricted annual limits" with respect to "essential health benefits" for plan years beginning before January 1, 2014 (discussed in further detail below).

Because regulations defining "essential health benefits" have not been issued, the Regulation (in the preamble) notes that the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits," so long as the definition is applied consistently.

Phase-In of Restricted Annual Limits

The Act prohibits annual limits on the dollar value of benefits generally, but allows "restricted annual limits" with respect to "essential health benefits" for plan years beginning before January 1, 2014. The restricted annual limits may be no more than:

- $750,000, for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011;
- $1.25 million, for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012; and
- $2 million, for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014.

Waiver Program

The Regulation provides for the Secretary of Health and Human Services to

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establish a program under which the requirements relating to restricted annual limits may be waived if compliance would result in a significant decrease in access to benefits or a significant increase in premiums. This provision is targeted to “limited benefit” (or “mini-med”) plans, which typically contain annual limits well below those contemplated by the Regulation.

Special Enrollment Right

Under the Regulation, individuals who reach a lifetime limit under a plan or health insurance coverage prior to the effective date and are otherwise still eligible under the plan or health insurance coverage must be provided, no later than the effective date, with (1) a notice that the lifetime limit no longer applies and (2) an enrollment or reinstatement opportunity.

Application to Grandfathered Plans

PHSA §2711 applies to all group health plans and group health insurance, whether or not grandfathered. However, the Act and the Regulations relating to the prohibition on annual limits, including the special rules regarding restricted annual limits for plan years beginning before January 1, 2014, do not apply to grandfathered individual health insurance coverage. In addition, certain changes to annual limits will end grandfathering treatment:

- A plan or health insurance coverage that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits imposes an overall annual limit on the dollar value of benefits.
- A plan or health insurance coverage that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.
- A plan or health insurance coverage that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

Practitioner’s Observation: Changes to annual limits will end grandfathering treatment, even if the post-modification limits are above the “restricted annual limits” thresholds.

Exclusion of a Benefit

The Regulation notes that an exclusion of all benefits for a condition is not considered to be an annual or lifetime dollar limit.

Restrictions on Rescissions (PHSA §2712)

Effective for plan years beginning on or after September 23, 2010, the Act prohibits plans and issuers from rescinding coverage once an individual is enrolled in coverage, unless the individual was involved in fraud or made an intentional misrepresentation of material fact. This standard applies to all rescissions, whether in the group or individual insurance market, whether coverage is insured or self-insured coverage, and whether or not a plan is grandfathered.

The Regulation provides the following guidance and clarifications:

- A rescission is defined as a cancellation or discontinuance of coverage that has retroactive effect. A prospective cancellation or discontinuance of coverage is not a rescission. Nor is a retroactive cancelation or discontinuance of coverage, to the extent it is attributable to a failure to timely pay required premiums.
- PHSA §2712 applies whether a rescission pertains to a single individual, an individual within a family, or an entire group of individuals.
- Omissions may be grounds for rescission, but only if fraudulent. However, inadvertent omissions should not be considered "fraudulent" or "an intentional misrepresentation of material fact."
- The standards apply to representations made on behalf of an individual or group seeking coverage, such as by an employer seeking to obtain coverage for its employees.
- 30 days' advance written notice must be provided to each participant who will be affected by a rescission.
- PHSA §2712 does not preempt other federal or state laws pertaining to rescissions, so long as the laws are more protective of individuals than PHSA §2712.

Patient Protections (PHSA §2719A)

Effective for plan years beginning on or after September 23, 2010, the Act establishes new requirements relating to the choice of a health care provider and availability of emergency services. These rules do not apply to grandfathered plans.

Choice of Health Care Provider

With respect to the choice of a health care provider, the Regulation provides:

- If a plan requires the designation of a primary care provider, a participant may designate any primary care provider who participates in the plan's network and who is available to accept the participant. For children, a pediatrician may be designated as the primary care provider.
- Plans and issuers that provide coverage for obstetric or gynecological care may not require prior authorization in order for a participant to obtain access to obstetrical or gynecological care from a obstetrics or gynecology specialist in the plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.
- The Regulation requires a plan to give notice of the above rights whenever the plan issues a Summary Plan Description or other similar description of benefits, and provides model language for the disclosure.

Emergency Services

If a plan or issuer covers any emergency services, it must provide for the services:

- without a prior authorization requirement, even for out-of-network

services;

- without regard to whether the provider of the services is in-network;
- if the services are out-of-network, without any administrative requirements or coverage limitations that are more restrictive than those imposed on in-network services; and
- without regard to any other term or condition of the coverage, other than (1) The exclusion of or coordination of benefits; (2) An affiliation or waiting period permitted under ERISA, the PHSA, or the Internal Revenue Code or (3) Applicable cost sharing.

In addition, if the emergency services are provided out-of network, the plan or issuer must comply with additional rules set forth in the Regulation regarding the minimum reimbursements for such services. The Regulation provides three alternate means of calculating the reimbursement amount, based on, respectively (1) the median charge for in-network services, (2) the amount the plan generally uses to calculate in-network services, and (3) the Medicare reimbursement rate. The reimbursement for out-of-network services must be the *greatest* of the three amounts.

Effective Date

The Regulation is effective 60 days following publication in the Federal Register. However, as noted above, the provisions discussed in this alert are all effective for plan years beginning on or after September 23, 2010 (for calendar year plans: January 1, 2011).

Endnotes

1 These new provisions are found in the Public Health Service Act.

2 A preexisting condition exclusion is, generally, 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 that date.

3 The Act sets forth a general list of essential health benefits which will be required under certain plans, such as plans sold under state exchanges. The essential health benefits are:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorders including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

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0489-0610-NAT-HCR