The Employee Benefits Group will present a seminar on this and other Health Care Reform topics on July 20, 2010, at the Marriott West Conference Center in St. Louis. For further information and to register, visit: www.thompsoncoburn.com/news-and-events/events/hc-reform-seminar.aspx

Health Care Reform: Regulations on Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

On June 22, 2010, the Departments of Treasury, Labor and Health and Human Services (the Departments) released interim final regulations (the Regulations) on the provisions of the Patient Protection and Affordable Care Act (the Act) relating to preexisting condition exclusions, lifetime and annual limits, rescissions and patient protections. This alert summarizes the Regulations and their impact on group health plans.

Preexisting Condition Exclusions

Prior to the Act, group health plans were permitted to impose limited preexisting condition exclusions if certain requirements were met under HIPAA. Now, the Act prohibits a group health plan from imposing any preexisting condition exclusions. This prohibition is effective with respect to plan years beginning on or after January 1, 2014, but for participants who are under 19 years of age, this prohibition becomes effective for plan years beginning on or after September 23, 2010. This prohibition applies regardless of grandfathered-plan status. (See our previous alert on Grandfathered-Plan status.)

The Regulations prohibit not just an exclusion of coverage of specific benefits associated with a participants preexisting condition, but also prohibit complete exclusion from a plan if that exclusion is based on a preexisting condition. The Regulations do not change the HIPAA rule that an exclusion of benefits for a condition under a plan is not a preexisting condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The Regulations reference examples in the HIPAA regulations on preexisting condition exclusions, which remain in effect.

Annual and Lifetime Limits

Under the Act, effective for plan years beginning on or after September 23, 2010, a group health plan may not impose any lifetime or annual limits on the overall dollar value of benefits for any participant. However, a plan may impose lifetime or annual per-individual dollar limits on specific benefits that are not essential health benefits. In addition, the Act permits a plan to impose restricted annual limits with respect to essential health benefits for plan years beginning before January 1, 2014. It appears that plans can still impose other limitations on benefits, such as limits on days of treatment

and number of visits, that are not based on dollar value. These rules apply regardless of grandfathered-plan status.

What are Essential Health Benefits? The Regulations define essential health benefits by reference to the Act and applicable regulations. Regulations under the Act defining essential health benefits have not yet been issued. Therefore, for plan 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. However, the plan must apply the definition of essential health benefits consistently. For example, a plan could not both apply a lifetime limit to a particular benefit (thus taking the position that it was not an essential health benefit) and at the same time treat that particular benefit as an essential health benefit for purposes of applying the restricted annual limit.

The Act defines essential health benefits to include at least the following general categories and the items and services covered within the 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.

What restricted annual limits can be placed on the dollar value of essential health benefits for plan years beginning before January 1, 2014? For plan years beginning before 2014, the Regulations adopt a three-year phased approach for restricted annual limits. Under the Regulations, annual limits on the dollar value of benefits that are essential health benefits may not be less than the following amounts:

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

Plans may use higher annual limits or impose no limits. Plans with plan years that begin between September 23 and December 31 have more than one plan year under which the $2 million minimum annual limit is available; however, a plan generally may not impose an annual limit for a plan year beginning after December 31, 2013.

Transitional Rules for Participants Whose Coverage Ended by Reason of Reaching a Lifetime Limit on the Dollar Value of All Benefits. A participant who reached a lifetime limit prior to the applicability date of the Regulations and is otherwise still eligible under the plan must be provided with a notice that the lifetime limit no

longer applies and must be provided an opportunity to enroll in the plan. The enrollment period must be at least 30 days. Notice and the opportunity to enroll must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Similarly, coverage of an individual who enrolls under these transitional rules must be effective no later than the first day of the first plan year beginning on or after September 23, 2010.

Notice may be provided to an employee on behalf of the employees dependent and may be included in other enrollment materials as long as the notice is prominent. Anyone eligible for an enrollment opportunity must be given the right to enroll in all of the benefit packages available to similarly-situated individuals upon initial enrollment.

Rules Regarding Rescissions

Under the Act, a group health plan may not rescind a participants coverage except in the case of fraud or an intentional misrepresentation of a material fact, as prohibited by the terms of the plan. This is effective for plan years beginning on or after September 23, 2010 and applies regardless of grandfathered-plan status.

The Regulations define rescission as a cancellation or discontinuance of coverage that has retroactive effect. Therefore, a cancellation or discontinuance of coverage that is effective prospectively is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

An example in the Regulations illustrates the limited ability of a plan to rescind coverage only in the case of fraud or intentional misrepresentation of material fact. In the example, only full-time employees working at least 30 hours per week are eligible for plan coverage. Individual B has coverage under the plan as a full-time employee but is reassigned to a part-time position. The plan mistakenly continues to provide health coverage to B, collecting premiums from B and paying claims submitted by B. After a routine audit, the plan discovers that B is part-time. Under the Regulations, the plan cannot cancel Bs coverage retroactive to the date B changed from a full-time to part-time employee. The plan may only cancel Bs coverage prospectively, subject to other applicable federal and state laws.

The Regulations clarify that the rules regarding rescission apply whether the rescission applies to a single individual, an individual within a family or an entire group of individuals. The Regulations provide that a group health plan must not rescind coverage under the plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. Therefore, a plan may rescind the coverage of an entire covered family unit due to a fraudulent act, practice or omission or intentional misrepresentation of a material fact of one of the covered family members, as long as the plan document permits rescission in such a case.

In order to rescind coverage, the plan must provide at least 30 days advance written notice to each affected participant. The Departments expect to issue further guidance on

notice requirements for cancellation of coverage other than rescission.

Plan sponsors should review their health plan documents to ensure that the plan provides for rescission in the event of fraud or intentional misrepresentation of material fact. The plan document should also set forth those instances in which coverage may be cancelled prospectively.

Mandated Patient Protections

The Act sets forth three requirements relating to the choice of a health care professional (which apply only with respect to a plan with a network of providers) and requirements relating to benefits for emergency services. These mandated patient protection requirements are effective for plan years beginning on or after September 23, 2010, and do not apply to grandfathered plans.

Choice of Health Care Professional. If a group health plan requires or provides for the designation of a participating primary care provider by a participant, the plan must permit each participant to designate any participating primary care provider who is available to accept the participant. Similarly, if a group health plan requires or provides for the designation of a participating primary care provider for a child, the plan must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics as the childs primary care provider if the provider participates in the plans network and is available to accept the child. Finally, if a group health plan provides coverage for obstetrical or gynecological care and requires designation of an in-network primary care provider, the plan may not require authorization or referral by the plan or any person (including a primary care provider) for a female participant who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics and gynecology.

The Regulations require plans to provide a notice of the above protections to participants. Model language is provided in the Regulations. The notice must be provided whenever the plan provides the participant with a summary plan description.

Emergency Services. If a plan provides benefits with respect to emergency services in an emergency department in a hospital, the plan must do so without the participant or provider having to obtain prior authorization (even if the emergency services are provided out-of-network) and without regard to whether the provider furnishing the services is an in-network provider. If emergency services are provided out-of-network, the plan may not impose administrative requirements or limitations on coverage that are more restrictive than those that apply to in-network emergency services.

In addition, for a plan with a network, the Regulations provide that copayments and coinsurance rates imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. Out-of-network providers, however, may balance-bill patients for the difference between the providers charges and the amount collected from the plan and patient in the form of a copayment or coinsurance amount. Because patients may be subject to balance-billing, the Regulations require plans to pay a reasonable amount for out-of-network emergency services according to objective standards set forth in the Regulations.

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