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Agencies Issue Guidance on Health Reform Provisions

Interim final regulations address preexisting condition exclusions, annual and lifetime limits, rescissions, and patient protections

The Departments of Health and Human Services, Labor and Treasury recently released another package of guidance on important provisions of the Patient Protection and Affordable Care Act (PPACA). Following the issuance of rules governing the extension of coverage to adult children and the maintenance or loss of “grandfathered plan” status,[1] the agencies published interim final regulations on several of the provisions of PPACA raising significant questions for employers maintaining group health plans and health insurance issuers. Specifically, the recent guidance covers preexisting condition exclusions, annual and lifetime limits on benefits, rescissions, and certain patient protection provisions. This *GT Alert* explains the rules set forth in these interim final regulations.

Preexisting Condition Exclusions

Generally. PPACA imposes a requirement on group health plans and health insurance coverage that prohibits the exclusion of coverage for any preexisting condition. For this purpose, a preexisting condition is defined as one that was present — regardless of whether the condition was diagnosed or the individual sought treatment — before the date on which the coverage is, or would be, effective. Under the interim final regulation, it is also clear that coverage itself under the plan or policy cannot be denied on the basis of any preexisting condition; however, it is not a violation of the law for a plan or insurance coverage to deny coverage to **all** participants or insureds for a specific medical condition.

Effective Date and Application to Grandfathered Plans. The prohibition against preexisting condition exclusions and discrimination on the basis of preexisting conditions in coverage decisions applies to grandfathered plans that are group health plans, but not to grandfathered plans that are individual health insurance coverage. These prohibitions apply generally for plan years or policy years beginning on or after January 1, 2014; however, these rules become effective for enrollees under age 19 as of the first plan or policy year beginning on or after September 23, 2010.

Limitations on Annual and Lifetime Limits on Coverage

Generally. Under PPACA, a group health plan or individual insurance coverage is generally prohibited from imposing annual or lifetime limits on the dollar value of benefits provided to any participant or beneficiary. This prohibition is generally effective for plan or policy years beginning on or after September 23, 2010.

Exceptions. There are two important exceptions to this prohibition. First, there is no restriction on the ability to limit benefits that do not relate to "essential health benefits" as defined under PPACA. Specific guidance interpreting the definition of "essential health benefits" has not yet been issued, but the interim final regulation indicates that for periods before guidance is issued, a group health plan or health insurance issuer can apply a reasonable, good-faith interpretation of the statutory definition of essential health benefits, provided that the interpretation is applied consistently.[2]

Second, for plan or policy years beginning before January 1, 2014, "restricted" annual limits can be imposed on essential health benefits. The relevant interim final regulation defines what are permissible "restricted" annual limits, using a phased-in approach. Specifically, annual limits will comply with the legal requirements if they satisfy the following schedule:

- For plan years beginning on or after September 23, 2010 but before September 23, 2011, the limit may not be less than $750,000;
- For plan years beginning on or after September 23, 2011 but before September 23, 2012, the limit may not be less than $1.25 million; and
- For plan years beginning on or after September 23, 2012 but before January 1, 2014, the limit may not be less than $2 million.

To comply with these rules, only essential health benefits can be counted for purposes of determining whether the limit has been reached.

Dollar-Denominated Arrangements (*e.g.*. FSAs, HSAs and HRAs). The interim final regulations make it clear that health flexible spending accounts (FSAs), which are subject to statutory limits on the amounts that may be contributed annually, are not subject to the prohibitions against annual limits. The regulations themselves do not specifically mention medical savings accounts (MSAs) or health savings accounts (HSAs), which are also subject to statutory limits on contributions, but the preamble indicates that they are not subject to the restrictions because they generally do not constitute "group health plans" within the meaning of PPACA. Technically, however, some MSAs or HSAs could fall within the definition of "group health plan," and a specific statement in the regulations that these arrangements are exempt from the prohibition on limits in the final regulations would be desirable.

The preamble to the regulations also specifically requests comments on the application to health reimbursement accounts (HRAs), which are not subject to any statutory limitations. While no rule is set forth in the interim final regulations themselves, the preamble indicates that those HRAs that are integrated with other health care coverage that alone would comply with the annual limit requirements will not violate the annual dollar limit requirements. "Stand-alone" HRAs, however, are not carved out from these rules.

The treatment of HRAs in the preamble does raise an interesting issue in the context of a plan's status as a grandfathered plan. As discussed in our previous *GT Alert*, *Interim Final Rules Issued for 'Grandfathered' Health Plans*, a plan can lose its status as a grandfathered plan if certain changes are made to the employer contributions under a group health plan, such as with respect to coinsurance, co-payments, deductibles, out-of-pocket maximums, and employer payments of premiums. It would seem that changes to, or elimination of, an HRA offered in connection with a group health plan could adversely affect the related plan's status as a grandfathered plan.

Effective Date and Application to Grandfathered Plans. The restrictions on lifetime limits are applicable to all grandfathered plans. The restrictions on annual limits, however, apply only to those grandfathered plans that are group health plans; they do not apply to grandfathered plans that are individual insurance coverage.

Reinstatement of Participants Who Previously Reached Limit — Notice Requirement. It is possible that a participant under a group health plan may have reached the lifetime limit previously or currently imposed under the plan. Accordingly, beginning no later than the first day of the first plan year beginning on or after September 23, 2010, individuals who have reached a lifetime limit before the effective date of the elimination of that limit and are otherwise still eligible under the plan or coverage must be provided with a notice that the lifetime limit no longer applies. Model language for this notice has been provided.

Prohibitions Against Rescissions

Generally. PPACA prohibits group health plan or health insurance issuer offering group or individual health insurance coverage from rescinding coverage except when an individual performs an act, practice or omission that constitutes fraud or made an ***intentional*** misrepresentation of material fact. The prohibition on rescissions also applies to the rescission of coverage for an entire group of individuals. For example, an insurer cannot rescind coverage to an entire employment-based group because of the actions of an individual within the group.

Definition of 'Rescission.' The interim final regulation makes it clear that relevant rules encompass the insurance-law concept of rescission. In other words, "rescission" is defined as a cancellation or discontinuance of coverage that has retroactive effect. Neither a cancellation or discontinuance with only a prospective effect constitutes a rescission. Similarly, a cancellation done retroactively due to failure to pay required premiums or contributions toward the cost of coverage on a timely basis is not a rescission.

Thus, plans remain free to change eligibility requirements on a prospective basis, subject, of course, to the ramification that a change in eligibility rules can cause a plan to lose its status as a grandfathered plan. On the other hand, plans that have a practice of rescinding coverage provided incorrectly to certain individuals (*e.g.*, dependents who were no longer eligible for coverage but were automatically or inadvertently kept on the plan) will no longer be able to do so on a retroactive basis unless there was fraud or intentional misrepresentation involved.

This new federal requirement strengthens previously existing law that had permitted rescissions even if the individual misrepresented a material fact unintentionally or unknowingly. Nevertheless, if applicable state law limits rescission beyond the federal standard, the state law will apply.

Notice Requirement. If a rescission is permitted under the PPACA rules, there is a new advance notice requirement that an individual be notified 30 calendar days before the rescission of coverage.

Effective Date and Application to Grandfathered Plans. Both the general prohibition on rescissions and the advance notice requirements apply to all plans, regardless of their status as a grandfathered plan, for plan or policy years beginning on or after September 23, 2010.

Patient Protections

Generally. PPACA imposes a number of new "patient protection" requirements. One set of these protections relates to an individual's right to choose certain health care providers. The other relates to the availability a emergency care services.

Choice of Health Care Provider. If a plan or issuer requires a participant, beneficiary or enrollee to designate a primary care provider, the plan or insurer must permit (and provide notice to) each participant to designate any participating primary care provider available to accept the participant. Relatedly, if a plan or insurer offers obstetric or gynecological (Ob/Gyn) or pediatric services, the plan or insurer must allow the same freedom of choice with respect to the service provider. Moreover, the Ob/Gyn doctor and the pediatrician must be treated as the individual's primary care physician for purposes of the services offered by that provider, and cannot require referrals from any other provider as a condition of receiving Ob/Gyn or pediatric services.

PPACA does not, however, relieve these providers from the requirements of following other plan or policy requirements relating to the provision of services, such as prior authorization and adherence to treatment plans approved by the plan or issuer. In addition, a plan may designate a primary care physician, Ob/Gyn provider or pediatrician for a participant until the participant selects one for himself or herself.

Emergency Services. A plan or health insurer providing emergency services must do so without the individual or the health care provider having to obtain prior authorizations and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services. For the purpose of this rule, emergency services are those that are provided in connection with an "emergency medical condition," which is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson possessing average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention could result in serious jeopardy to the health of the individual (or an unborn child), serious impairment of bodily function or serious dysfunction of any body part or organ.

In this context, "emergency services" are defined to include a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities at the hospital, as required to stabilize the patient.

In addition, PPACA provides that cost-sharing requirements (copayments, coinsurance) 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 may balance bill patients for the difference between their charges and the amount collected from the plan and patient in the form of copayment or coinsurance. To ensure fairness to participants in this regard, however, the interim final regulations require a plan or insurer to pay a "reasonable amount" for out-of-network services.

A reasonable amount is equal to the greatest of: (1) the amount negotiated with in-network providers for emergency services furnished; (2) the amount calculated using the same method for determining payments for out-of-network services (usual, customary and reasonable charges), but applying in-network cost-sharing; and (3) the amount paid under Medicare for the emergency service.

Notice Requirement. A plan or insurer must provide notice informing each participant of the terms of coverage regarding designation of a primary care physician, Ob/Gyn provider or pediatrician. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage, or in the individual market, provides a primary subscriber with a policy, certificate, or contract of health insurance. Model language for this notice has been provided.

Effective Date and Application to Grandfathered Plans. These patient protection provisions of PPACA are effective for plan or policy years beginning on or after September 23, 2010. These provisions do not apply to grandfathered plans. Accordingly, the possibility of being subjected to additional costs that may be associated with providing these patient protections should be carefully considered by any employer contemplating making changes to a group health plan that could cause the plan to lose its status as a grandfathered plan.

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[1] For further information on these regulations, please see our previous *GT Alerts*.
[2] Section 1302(b) of PPACA 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."

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