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Interim Final Regulations Issued for Health Plans Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, and Rescission Prohibition

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June 23, 2010

On June 22, 2010, the three primary agencies charged with regulating and enforcing the federal government's health care reform effort (the U.S. Department of Treasury, the U.S. Department of Health and Human Services, and the U.S. Department of Labor) released their second set of interim final regulations (see our June 15, 2010 *On Benefits* for a discussion of the first set of interim final regulations) that implement a new patient's bill of rights under the Patient Protection and Affordable Care Act and the subsequent Reconciliation Act (collectively, "PPACA").

The interim final regulations are intended to help individuals with pre-existing conditions gain coverage and keep it, protect choice of doctors and end lifetime limits on the care consumers may receive. The regulations also ensure that employees can choose the primary care doctor or pediatrician they want from a plan's provider network, ensure that employees can see an OB-GYN without needing a referral, and provide that insurance companies will not be able to require prior approval before employees seek emergency care at a hospital outside a plan's network.

In this *On Benefits*, we review the second set of interim final regulations and explore how the new rules will help enforce the health care reform provisions.

Pre-existing Conditions. The overview of the interim final regulations note that PPACA added a section that amended the Health Insurance Portability and Accountability Act (HIPAA) rules relating to pre-existing condition exclusions to provide that a group health plan may not impose any pre-existing condition exclusion. 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 becomes effective for plan years beginning on or after September 23, 2010. The regulations further provide that until PPACA rules take effect, HIPAA rules on pre-existing condition exclusions continue to apply.

PPACA prohibits not just excluding coverage of specific benefits associated with an enrollee's pre-existing condition; it also prohibits excluding an enrollee from the plan if that exclusion is based on a pre-existing condition. The regulations do not change the HIPAA rule that an exclusion of benefits for a condition under a plan or policy is not a pre-existing condition exclusion if the exclusion applies regardless of when the condition arose relative to the effective date of coverage.

Benefits Limits. The interim final regulations also generally prohibit group health plans offering group health insurance cov-

erage from imposing lifetime or annual limits on the dollar value of health benefits. The restriction applies differently to certain account-based plans though, especially where other rules apply to limit the benefits available.

For example, under Section 9005 of PPACA, salary reduction contributions for health flexible spending arrangements (FSAs) are specifically limited to $2,500—indexed for inflation—per year, for taxable years beginning in 2013. The regulations provide that restrictions on annual limits in Section 2711 of the Public Health Service Act, as amended by PPACA, do not apply to health FSAs.

The restrictions on annual limits also do not apply to medical savings accounts (MSAs) and health savings accounts (HSAs). Annual contributions to MSAs and HSAs are subject to specific statutory provisions that require that the contributions be limited.

The regulations adopt a three-year phased approach for restricted annual limits. 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 before January 1, 2014:

- 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.
- For plan years beginning on or after September 23, 2012, but before January 1, 2014, $2 million.

Since these are minimums for plan years beginning before 2014, plans may use higher annual limits or impose no limits. However, a plan generally may not impose an annual limit for a plan year beginning after December 31, 2013. Individuals who reached a lifetime limit under a plan or health insurance coverage prior to the applicability date of the regulations and are otherwise still eligible under the plan or health insurance coverage must be provided with a notice that the lifetime limit no longer applies.

Rescission Prohibition. PPACA prohibits all group health plans and plans offering individual coverage from rescinding coverage except in the case of fraud or an intentional misrepresentation of a material fact. For these purposes, a rescission is a cancellation or discontinuance of coverage that has retroactive effect.

The interim final regulations expand on already-existing policies in the Public Health Service Act. They also clarify that other requirements of Federal or State law may apply in connection with a rescission or cancellation of coverage beyond the standards established in the Public Health Service Act, if they are more protective of individuals.

First, the regulations clarify that the rules of the Public Health Service Act apply whether the rescission applies to a single individual, an individual within a family, or an entire group of individuals. Second, they clarify that the rules of the Public Health Service Act apply to representations made by the individual or a person seeking coverage on behalf of the individual. Finally, the Public Health Service Act refers to acts or practices that constitute fraud. The regulations clarify that, to the extent that an omission constitutes fraud, that omission would permit the plan or issuer to rescind coverage.

The regulations provide that a group health plan, or an issuer offering group health insurance coverage, must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded. The

notice must be provided regardless of whether the rescission is of group or individual coverage; or whether, in the case of group coverage, the coverage is insured or self-insured, or the rescission applies to an entire group or only to an individual within the group.

Other Items. Under the interim final regulations, a plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider. A plan or issuer must also permit the designation of a pediatrician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child.

A plan or issuer must also inform each participant that the plan or issuer may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. However, nothing in the regulations precludes a plan or issuer from requiring an in-network obstetrical or gynecological provider to otherwise adhere to policies and procedures regarding referrals, prior authorization for treatments, and the provision of services pursuant to a treatment plan approved by the plan or issuer. The plan or issuer must treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, by the professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

Finally, the regulations require that a plan or health insurance coverage providing emergency services must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are provided out of network) and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services. The emergency services must be provided without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, an affiliation or waiting period or applicable cost-sharing requirements. For a plan or health insurance coverage with a network of providers that provides benefits for emergency services, the plan or issuer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.

Additionally, for a plan or health insurance coverage with a network, the regulations provide rules for cost-sharing requirements for emergency services that are expressed as a copayment amount or coinsurance rate, and other cost-sharing requirements. Cost-sharing requirements expressed as a copayment amount or coinsurance rate 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 may, however, also balance bill patients for the difference between the providers' charges and the amount collected from the plan or issuer and from the patient in the form of a copayment or coinsurance amount.

The interim final regulations are scheduled for publication in the June 28, 2010 *Federal Register* and take effect Aug. 27, 2010. As we previously noted, we expect to see additional guidance from the three primary agencies in the coming months. Brucker & Morra, APC will provide updates as they become available.

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