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Health Care Reform – New Guidance on Pre-existing Condition Limitations, Lifetime and Annual Limits, Rescissions, and Patient Protections

On June 22, 2010, the Department of Treasury, Department of Health and Human Services, and Department of Labor jointly issued interim final regulations implementing several provisions of the *Patient Protection and Affordable Care Act (PPACA)* that affect employer-sponsored group health plans. These provisions are generally effective for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011, for calendar year plans).

New Guidance. The new guidance addresses the following issues:

- **Pre-existing Condition Limitations.** Group health plans may not impose pre-existing condition limitations for children under age 19 for plan years beginning on or after September 23, 2010, and for individuals of all ages for plan years beginning on or after January 1, 2014. The regulations clarify that plans may not deny specific benefits to currently enrolled individuals or deny coverage to applicants based on a pre-existing condition.

- **Lifetime Limits.** Group health plans may not impose lifetime limits on the dollar value of essential health benefits. The regulations provide that, until further guidance is issued defining essential health benefits, plan sponsors are to apply a reasonable, good faith interpretation of the term by reference to PPACA.

    - **Transition Rules.** Individuals who previously reached a lifetime limit under the plan must be notified that the lifetime limit no longer applies. Individuals who are no longer enrolled in the plan must also be notified that a special enrollment opportunity will be available.

- **Restricted Annual Limits.** For plan years beginning prior to January 1, 2014, group health plans may not impose annual dollar limits on essential health benefits that are less than:

    - $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;

    - $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and

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

  Thereafter, annual dollar limits on essential health benefits are completely prohibited. These restrictions do not apply to health FSAs, HSAs, or MSAs, or to HRAs that are integrated with other coverage that complies with the restrictions or that are stand-alone, retiree-only plans. The Department of Health and Human Services is authorized to establish a program under which these restrictions may be waived if compliance would result in a significant loss of coverage or increase in premiums (*e.g.*, a limited-scope "mini-med" plan might seek a waiver).

- **Prohibition on Rescissions.** Group health plans may not rescind coverage except in cases of fraud or intentional misrepresentation of material fact. The regulations require plans to provide 30 days advance written notice prior to any such rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. A retroactive cancellation or discontinuance of coverage for failure to timely pay premiums or contributions is not a rescission.

- **Choice of Health Care Professional.** Group health plans that require or permit individuals to designate an in-network primary care provider must allow individuals to designate any available in-network primary care provider, including a pediatrician. Plans that require individuals to designate an in-network primary care provider may not require prior authorization for obstetrical or gynecological care provided by an in-network specialist. Notice of these rights must be provided with the summary plan description or other similar benefit descriptions.

- **Benefits for Emergency Services.** Group health plans that provide coverage for emergency services must do so without requiring prior authorization (even for out-of-network services) and without regard to whether the services are furnished by a participating provider. Plans may not impose more restrictive administrative requirements or higher cost-sharing requirements on benefits for out-of-network emergency services than would be imposed if the services were provided in-network.

Application to Grandfathered Plans. The new rules regarding pre-existing condition limitations, lifetime and annual limits, and rescissions apply to all group health plans, regardless of grandfathered status. The rules related to the choice of a health care professional and benefits for emergency services do not apply to grandfathered plans.

Next Steps. To comply with the new guidance, plan sponsors will need to:

- Amend plan documents to eliminate pre-existing condition limitations for children under age 19 for plan years beginning on or after September 23, 2010, and for individuals of all ages for plan years beginning on or after January 1, 2014.

- Amend plan documents to remove lifetime limits, notify all individuals who previously reached a lifetime limit by the first day of the first plan year beginning on or after September 23, 2010, and provide special enrollment for

eligible individuals who previously reached a lifetime limit.

- Track payments for essential health benefits and ensure the plan is complying with the annual limit restrictions for plan years beginning prior to January 1, 2014.

- Review routine plan audit rules for compliance with the prohibition on rescissions.

- Prepare the notice of rights related to the choice of a health care professional and distribute with the summary plan description and other similar benefit descriptions.

- Ensure copayment amounts and coinsurance rates imposed for out-of-network emergency services comply with the new cost-sharing requirements for emergency services.

We will continue to follow the legislation closely and provide you with updates as well as our analysis of what it means to you.

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