

# Compensation and Benefits Insights

AUGUST 2010

## Interim Final Regulations Under PPACA: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

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The Patient Protection and Affordable Care Act (“PPACA”) and the Health Care and Education Affordability Reconciliation Act of 2010 (the “Reconciliation Act”), both signed into law in March 2010, enacted sweeping changes to the U.S. healthcare system and made in relevant part broad changes to the rules which had sanctioned limitations and restrictions on health care coverage, including coverage under group health plans and group and individual health insurances.

On June 28, the Departments of Health and Human Services, Labor, and the Treasury (the “Departments”) jointly issued interim final regulations (the “Interim Regulations”) to implement the provisions of PPACA that prohibit the use of preexisting condition exclusions, eliminate lifetime and annual dollar limits on benefits, restrict contract rescissions, and provide patient protections. This article describes the application of the Interim Regulations to group health plans and health insurers offering group or individual health insurance coverage.

### Prohibition on Preexisting Condition Exclusions

Currently, existing rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permit group health plans to impose limited exclusions of coverage based upon a preexisting condition. In addition, since HIPAA does not apply to individual health insurance coverage, individual policies can also impose preexisting condition limitations. PPACA changes the landscape by prohibiting group health plans and individual health insurance policies from imposing any preexisting condition exclusions. This prohibition will generally be effective for plan and policy years beginning on or after January 1, 2014 but under certain circumstances can be effective as early as plan or policy years beginning on or after September 23, 2010.

A “preexisting condition exclusion” is broadly defined as a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or, if coverage is denied, the date of the denial), whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day. The prohibition against an exclusion for a preexisting condition includes any limitation or exclusion of benefits as a result of information relating to an individual’s health status before the individual’s effective date of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

# Compensation and Benefits Insights

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*Observation:* This rule expands HIPAA’s definition of “preexisting condition exclusion” by prohibiting not just an exclusion of coverage of *specific benefits* associated with a preexisting condition, but also a *complete exclusion* from such plan or coverage, if that exclusion is based on a preexisting condition.

Note that the preexisting condition prohibition does not apply to an exclusion of benefits for a condition that is applicable regardless of when the condition arose relative to the effective date of coverage. For example, if Plan A provides coverage for treatment of cleft palate in children, but only when the child being treated has been continuously covered under the plan from his or her date of birth, provision of coverage is dependent on when the condition arose (at birth) relative to the effective date of coverage (from birth); therefore, Plan A’s limitation on coverage would be considered a prohibited preexisting condition exclusion for plan and policy years beginning on or after September 23, 2010. However, if Plan A generally excludes coverage for treatment of cleft palate in children, coverage is not dependent on when the condition arose relative to the effective date of coverage, and Plan A’s limitation on coverage would be a permissible preexisting condition exclusion.

The preexisting condition prohibition is generally effective for plan and policy years beginning on or after January 1, 2014. Prior to that date, HIPAA’s current rules relating to preexisting conditions will apply. However, for enrollees under age 19, the prohibition becomes effective for plan and policy years beginning on or after September 23, 2010. The prohibition on preexisting conditions applies to all group health plans (whether or not grandfathered), as well as to non-grandfathered individual health insurance coverage.

## **Prohibition on Lifetime and Annual Limits**

PPACA prohibits group health plans and insurers offering group or individual health insurance coverage from imposing lifetime or annual limits on the dollar value of “essential health benefits.” With respect to lifetime limits, the prohibition applies to plan or policy years beginning on or after September 23, 2010, and with respect to annual limits, the prohibition applies to plan or policy years beginning on or after January 1, 2014, subject to a three-year phased implementation of “restricted annual limits.”

PPACA defines “essential health benefits” to include at least the following: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) maternity and newborn care; (v) mental health and substance abuse disorder services, including behavioral health treatment; (vi) prescription drugs; (vii) rehabilitative and habilitative services and devices; (viii) laboratory services; (ix) preventive and wellness services and chronic disease management; and (x) pediatric services, including oral and vision care.

*Observation:* The definition of “essential health benefits” is to be further defined in forthcoming regulations. The Departments will take into account good faith efforts to comply with a “reasonable interpretation” of this term, so long as the good faith interpretation is applied consistently, until the plan or policy year after such regulations are issued.

The Interim Regulations clarify that a plan or issuer may continue to impose annual or lifetime per-individual dollar limits on benefits that are not “essential health benefits” (subject to the requirements of other applicable Federal and State laws). Further, a plan or issuer may continue to exclude all benefits for a specific condition but, if coverage is provided to any extent with respect to a condition, PPACA’s annual and lifetime dollar limit rules will apply to such coverage.

The Interim Regulations provide that the prohibitions on annual and lifetime limits do not apply to salary reduction contributions for health flexible spending accounts (often called “Health FSAs”), Medical Savings Accounts (“MSAs”), Health Savings Accounts (“HSAs”) and Health Reimbursement Accounts (“HRAs”) if these arrangements are integrated with other coverage as part of a group health plan and the other coverage

# Compensation and Benefits Insights

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alone would comply with the annual limit requirements. Further, the prohibitions do not apply to stand-alone HRAs that are limited to retirees. Whether the prohibitions will apply to stand-alone HRAs that are not retiree-only plans is an open question.

## *Annual Limits*

While there will be a flat prohibition against any annual limits on the dollar value of “essential health benefits” for plan and policy years beginning on or after January 1, 2014, there will be a more limited prohibition which will begin to apply for plan and policy years beginning on or after September 23, 2010. More specifically, the annual limits on the dollar value of “essential health benefits” may not be less than the following:

- \$750,000 annual limit (per individual) for plan or policy years beginning on or after September 23, 2010, but before September 23, 2011;
- \$1,250,000 annual limit (per individual) for plan or policy years beginning on or after September 23, 2011, but before September 23, 2012; and
- \$2,000,000 annual limit (per individual) for plan or policy years beginning on or after September 23, 2012, but before January 1, 2014.

Plans may apply annual limits higher than those listed above, or may impose no annual limits. When determining whether an individual has reached an annual limit, only “essential health benefits” are taken into account.

*Observation:* Note that other kinds of restrictions on the coverage of essential health benefits (such as the number of wellness visits that will be covered each year) are not addressed in the Interim Regulations.

The prohibition on annual limits applies to all group health plans and group health insurance coverage (whether or not grandfathered), but does not apply to individual health insurance policies that are grandfathered. Be aware that changing a plan’s annual limit may result in the loss of a plan’s grandfathered status. Under regulations previously issued, a plan will lose grandfathered plan status if:

- it adds an overall annual limit on the dollar value of “essential health benefits” after March 23, 2010;
- it imposes an annual limit at a dollar value that is lower than the dollar value of its lifetime limit as in effect on March 23, 2010; and
- it decreases the dollar value of its annual limit as in effect on March 23, 2010.

## *Lifetime Limits*

The Interim Regulations prohibit lifetime limits on the dollar value of “essential health benefits” for plan or policy years beginning on or after September 23, 2010. Plans and insurers must notify individuals who reached a lifetime limit under a plan or health insurance coverage that the lifetime limit no longer applies, and that the individual, if covered, is once again eligible for benefits under the plan. Such individuals must be treated as a HIPAA special enrollee and therefore given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment. Plans and insurers must provide these notices and the

# Compensation and Benefits Insights

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enrollment opportunities not later than the first day of the first plan or policy year beginning on or after September 23, 2010. The Interim Regulations provide model language to inform participants of these rights, which can be seen through the link [www.dol.gov/ebsa/lifetimelimitsmodelnotice.docere](http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.docere).

*Observation.* Because the notices discussed above must be provided not later than the first day of the first plan or policy year beginning on or after September 23, 2010, calendar year plans will need to quickly determine which individuals should receive such notices, and provide both the notices and the enrollment opportunities prior to January 1, 2011.

The requirements relating to the prohibition on lifetime limits apply to all group health plans and health insurance issuers offering group or individual health insurance coverage, whether or not the plan qualifies as a grandfathered health plan.

## **Prohibition on Rescissions**

PPACA provides that a group health plan, or a health insurance issuer offering group or individual health insurance coverage, cannot rescind coverage except in the case of fraud (including an omission that constitutes fraud) or an intentional misrepresentation of a material fact. This rule applies whether the rescission applies to a single individual, an individual within a family, or an entire group of individuals. It also applies to representations made by the individual, as well as by persons seeking coverage on behalf of the individual (such as a plan sponsor making representations to an insurance company regarding the prior claims experience of the group).

*Observation:* A showing of “fraud or intentional misrepresentation” is a high threshold. Therefore, plan sponsors should review their summary plan descriptions and other plan communications carefully to determine whether any ambiguous terms or provisions could provide the basis for a participant’s contention that a representation was merely inadvertent.

The Interim Regulations clarify that a “rescission” is a cancellation or discontinuance of coverage that has retroactive effect. It does not cover a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively only because it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. A plan or insurance company must provide at least 30 calendar days’ advance notice to an individual before their coverage can be rescinded.

The rules on rescissions and required advance notice apply to both grandfathered and non-grandfathered plans for plan or policy years beginning on or after September 23, 2010.

## **Patient Protections**

PPACA imposes (i) a set of three requirements relating to the choice of a health care professional applicable to plans and health insurance coverage with a network of providers, and (ii) requirements relating to benefits for emergency services. These requirements are collectively referred to as “patient protections.”

### *Choice of Health Care Professional*

If a group health plan or an insurance company offering group or individual health insurance coverage requires or permits a participant (or beneficiary or enrollee) to designate a participating primary care provider, the Interim Regulations require such plan or insurance company to permit the designation of any participating primary care provider who is accepting new patients. Similarly, if a plan or insurance company requires or

# Compensation and Benefits Insights

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permits an individual to designate a pediatrician for a covered child, it must permit the designation of any participating pediatrician who is accepting new patients.

Where a plan or insurance company provides OB/GYN coverage and requires the designation of an in-network primary care provider, the Interim Regulations prohibit it from requiring authorization or referral for OB/GYN care provided by an in-network OB/GYN provider. However, nothing precludes the plan or insurance company from requiring that an in-network OB/GYN provider adhere to policies and procedures regarding referrals, prior authorization treatments and the provision of services pursuant to a treatment plan approved by the plan or insurance company.

The Interim Regulations provide model language to inform participants of these rights, which can be seen through the link [www.dol.gov/ebsa/patientprotectionmodelnotice.docere](http://www.dol.gov/ebsa/patientprotectionmodelnotice.docere). The notice must be provided whenever the plan or insurer provides a participant with a summary plan description or other similar description of benefits.

## *Emergency Services*

The Interim Regulations require that any plan or insurance company providing emergency services as a benefit must provide such services (i) without an individual having to obtain prior authorization, even when the services are provided out-of-network, and (ii) without regard to whether the health care provider furnishing the emergency services is an in-network provider. Further, for plans or coverage utilizing a network of providers, such plans and coverage cannot impose administrative requirements or limitations on benefits for out-of-network emergency services that are more restrictive than such requirements or limitations for in-network emergency services.

Cost-sharing requirements (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. However, out-of-network providers may “balance bill” patients for the difference between their charges and the amount paid by the plan or issuer. In order to ensure that patients are not burdened with excessively high “balance bills,” and to ensure that a plan pays a “reasonable amount” of the cost of emergency services, the dollar value of the benefits provided by a plan or insurance company for out-of-network emergency services must equal the greatest of the following amounts:

- the median amount negotiated with in-network providers for the emergency service;
- the amount calculated using the same method the plan uses for determining payments for out-of-network services (usual, customary and reasonable charges), but substituting the in-network cost-sharing provisions; and
- the amount paid under Medicare for the emergency service.

Other cost-sharing requirements, such as a deductible or out-of-pocket maximum, may be imposed on out-of-network emergency services only if the cost-sharing requirements generally apply to out-of-network benefits. The purpose of this rule is to prohibit a plan or health insurance coverage from structuring plan rules so as to require a participant to pay more for emergency services than for general out-of-network services.

# Compensation and Benefits Insights

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These patient protections and the applicable Interim Regulations do not apply to grandfathered plans. Non-grandfathered plans must comply with the new rules starting with the first plan or policy year beginning on or after September 23, 2010.

King & Spalding would be pleased to provide additional information about the new Interim Regulations and how they will impact your health plan arrangements.

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