



Fourth Interim Final Rule Patient Protection and Affordable Care Act (PPACA): Pre-Existing Condition Exclusions, Annual and Lifetime Limits, Rescission, Choice of Providers and Emergency Services

Last week the U. S. Departments of Treasury, Labor, and Health and Human Services jointly issued its fourth set of interim final regulations under PPACA. This set of rules provides guidance regarding lifetime and annual dollar limits on benefits, preexisting condition exclusions, rescissions, and patient protections. A 60-day comment period began on June 22, 2010, the date of publication.

The complete interim final regulations can be viewed at <http://www.dol.gov/ebsa/healthreform/>.

Except where noted in this memorandum, most of the provisions in the new rule apply to both insured and self-funded health plans for plan or policy years beginning on or after September 23, 2010 (January 1, 2011 for calendar plan years).

The requirements of the new rule are summarized below:

Pre-Existing Condition Exclusions

A plan or issuer offering group health insurance coverage may not impose any pre-existing condition exclusions (PCE) on enrollees under the age of 19 for plan years beginning on or after September 23, 2010. This requirement extends to all individuals, regardless of age, covered under the plan for plan years beginning on or after January 1, 2014.

The regulation applies to grandfathered and non-grandfathered plans and applies to both self-funded and fully insured plans.

Note: An exclusion for a particular benefit will be permitted if it applies regardless of when the condition arose relative to the effective date of the coverage. As an example, a policy that excludes benefits for oral surgery related to a traumatic injury that happened before the effective date of coverage would be considered a PCE because the exclusion is based on the fact that the condition was present before the effective date of coverage. However, if the exclusion applies regardless of when the injury occurred, the exclusion would be permissible.

The regulation makes clear that the PCE term includes any limit 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 denial.

The PCE definition also includes any limitation or exclusion based on information relating to an individual's health status, "such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to an individual, or review of medical records relating to the pre-enrollment period." This new language could impact health risk assessments and wellness program screenings.

Additionally, since the definition of PCE is somewhat different than the current HIPAA definition of the same, a plan amendment of the current definition will be necessary.

Annual/Lifetime Limits

A plan or issuer generally may not establish or maintain any annual or lifetime limit on the dollar amount of “essential health benefits” for any individual. The law provides for a limited period of transition prior to January 1, 2014 during which a plan or issuer may impose “restricted” annual limits, which are further defined in the regulations. A plan or issuer may exclude all benefits for a condition; however, if any benefits are provided for a condition, then the prohibition regarding annual or lifetime limits applies.

Note: The regulation appears to apply to the total dollar limit and does not extend the requirement to specific treatment limits, i.e., day or visit limits, or per procedure dollar limits. Thus, non-dollar limits would appear to be permitted.

A plan or issuer may impose annual or lifetime dollar limits with respect to any individual on benefits that are not “essential health benefits” to the extent that such limits are permitted under other applicable federal or state law.

The regulation applies to insured and self-funded plans. The lifetime limit rules apply to all grandfathered and non-grandfathered plans. The annual limit rules apply to grandfathered and non-grandfathered group plans.

The regulation’s limitations apply to “essential health benefits” which are not defined beyond the categories listed in PPACA. These categories are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Note: Until further guidance is issued more fully defining these categories, the regulations impose a good faith requirement with respect to the interpretation of the term “essential health benefits” for plan/policy years beginning on or after September 23, 2010. However, plans must apply the definition of “essential health benefits” on a consistent basis for purposes of applying the lifetime and annual limit restrictions.

What happens if someone has reached their lifetime limit in the past? Do they have to be let back in? When an individual already has reached a lifetime maximum, the plan must provide an opportunity to re-enroll in coverage. The one-time re-enrollment right is similar to the re-enrollment rights under the new age 26 dependent rules coverage or special HIPAA enrollment rights. The re-

enrollment right must extend for 30 days and begin no later than the effective date of the requirement, or beginning of the plan year. The U.S. Department of Labor has issued a model notice for plans to use to comply with both this re-enrollment right and the age 26 re-enrollment right. The enrolling individual will be treated as a HIPAA special enrollee and must be offered all benefit packages available to similarly situated individuals who did not lose coverage.

The annual limits exclusions are not applicable to health reimbursement arrangements that are “integrated with other coverage” like another traditional plan, where that other coverage alone would need to comply with the annual/lifetime limit requirements apply. Retiree only coverage, and HIPAA accepted benefits (stand alone dental and vision plans) are not subject to the prohibition on annual limits.

Patient Protections Regarding Provider Choice, Pre-Authorization, and Emergency Care Services

Plans and issuers offering coverage must allow an individual to choose his or her own primary care physician, must allow a child to designate a pediatrician as his or her primary care physician, and must allow a woman to see a health care professional specializing in obstetrics or gynecology without an authorization or referral requirement.

The regulation applies to non-grandfathered plans and only applies where the plan uses a network of providers. It applies to both self-funded and insured non-grandfathered plans.

If a plan or coverage provides any benefits with respect to emergency services in a hospital, the plan or coverage must do so without the individual or the health care provider having to obtain prior authorization, even if the emergency services are out-of-network, and without regard to whether the provider furnishing the emergency services is an in-network provider.

This regulation applies to both self-funded and insured plans, but only applies to non-grandfathered plans.

Cost sharing requirements for deductibles and out-of-pocket maximums can be imposed with respect to out-of-network coverage if the deductible or out-of-pocket maximum applies to all out-of-network benefits generally and not just emergency services. An example from the regulation is as follows: A plan imposes a \$250 deductible for in-network care and \$500 deductible for out-of-network care. An individual has incurred and submitted \$260 of covered claims prior to receiving out-of-network emergency services. The example says the plan is not required to pay benefits for emergency services by an out-of-network provider because the individual has not satisfied the \$500 out-of-network deductible, which deductible applies to all out-of-network benefits, not just emergency services. However, the plan must credit the amount the individual pays against the out-of-network deductible for future services.

The regulations provide a complicated set of rules regarding the setting of cost-sharing for out-of-network emergency services. Generally, the rules strive to ensure that meaningful coverage is provided for emergency services before balanced billing begins.

Rescission

The rule on rescissions essentially builds on already-existing federal requirements regarding cancellation of coverage. Generally, an issuer or plan cannot cancel, or fail to renew, coverage for an individual or group for any reason other than nonpayment of premiums, fraud, intentional misrepresentation of material fact, withdrawal of a product or withdrawal of an issuer from the market, movement of an individual or employer outside of the service area, or cessation of association membership with corresponding association coverage. Additionally, the coverage may not be rescinded unless and until requisite 30-day advance written notice is provided to the individual.

Rescission applies to grandfathered and non-grandfathered plans and applies to self-funded and insured plans.

Note: The regulation only addresses rescissions, not cancellations.

Again, we hope you find this information to be useful.