

## Federal Agencies Issue Interim Final Regulations For Health Care Reform Coverage Mandates

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (together, the "Health Care Reform Law") impose new requirements on group health plans and group health insurance coverage relating to pre-existing condition exclusions, lifetime and annual dollar limits on benefits, recissions of coverage, and patient protections. These new requirements generally are effective for plan years beginning on or after September 23, 2010 (that is, January 1, 2011 for calendar year plans). In recognition of this looming deadline, IRS, DOL and HHS have jointly issued interim final regulations governing implementation of the new requirements.

### Pre-Existing Condition Exclusions

For plan years beginning on or after September 23, 2010, group health plans and group health insurance issuers are not permitted to deny coverage or benefits to any enrollee under age 19 because of a pre-existing condition. This prohibition is extended to all enrollees, regardless of age, for plan years beginning on or after January 1, 2014.

- The prohibition applies to both denial of enrollment and denial of specific benefits based on a pre-existing condition.
- The prohibition does not apply, however, to an exclusion of benefits for a specified condition, where the exclusion does not depend on when the condition arose relative to the effective date of coverage.
- A pre-existing condition is one that is present before the date of enrollment for coverage, whether or not medical advice, diagnosis, care or treatment was recommended or received before that date.
- Grandfathered health plans that are group health plans or group health insurance coverage are subject to the prohibition.

### Lifetime and Annual Limits

For plan years beginning on or after September 23, 2010, group health plans and health insurance issuers are not permitted to impose lifetime limits, or annual limits in excess of those permitted by regulation, on the dollar value of health benefits. This proscription is extended to any annual limit on the dollar value of benefits for plan years beginning on or after January 1, 2014. No regulatory exception will apply after that date.

- The restriction on annual limits does not apply to health flexible spending arrangements, Medical Savings Accounts or Health Savings Accounts. Similarly, the restriction on annual limits does not apply to Health Reimbursement Arrangements that are integrated with other coverage as part of a group health plan, so long as aggregate benefits under the group health plan as a whole satisfy the annual limit requirements. The federal agencies have requested comments regarding the application of restrictions on annual limits to stand-alone Health Reimbursement Arrangements that are not retiree-only plans. (The Health Care Reform Law coverage mandates do not apply generally to retiree-only group health plans, including retiree-only Health Reimbursement Arrangements.)
- A group health plan or health insurance issuer may apply annual or lifetime per individual dollar limits on specific covered benefits that are not "essential health benefits." The Health Care Reform Law defines "essential health benefits" by example.
- The interim final regulations do not preclude a group health plan or health insurance issuer from excluding all benefits for a specific condition, but if any benefits are provided for that condition, then the restrictions on lifetime and annual dollar limits apply.
- The restrictions on annual dollar limits are phased in over three years. Annual limits cannot be 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. No annual limits are permitted for plan years beginning on or after January 1, 2014.

- The restrictions on annual limits apply on an individual-by-individual basis. An overall annual dollar limit on benefits for family coverage cannot be applied to deny any covered family member the required minimum annual benefits for a plan year. In applying annual limits, the group health plan or group health insurance coverage may take into account only payments for essential health benefits.
- HHS will establish a program providing for waiver of the restrictions on annual limits if those restrictions would result in a significant decrease in access to benefits or a significant increase in premiums. This is intended to preserve access to needed services at reasonable cost under limited benefit plans or "mini-med" plans.
- Individuals who have reached a lifetime limit under a group health plan or health insurance coverage must be given written notice that the lifetime limit no longer applies and an opportunity to re-enroll in the plan or coverage. The notice and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. The enrollment opportunity must be for a period of at least 30 days and must provide for coverage beginning no later than the first day of the first plan year beginning on or after September 23, 2010. Notices may be included with other enrollment materials distributed to employees.
- The restrictions on lifetime and annual limits apply to grandfathered health plans that are group health plans or group health insurance coverage. The interim final regulations for grandfathered plans issued previously include separate restrictions on annual limits, which are applied independently from these general restrictions on annual limits and could result in loss of grandfathered status. You can read our summary of the interim final regulations for grandfathered plans by clicking on the following link: [HHS/DOL/IRS Release Interim Final Regulations for Grandfathered Plans Under Health Care Reform Law](#)

### **Rescission of Coverage**

For plan years beginning on or after September 23, 2010, group health plans and group health insurance coverage are not permitted to rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact.

- Other federal or state law may apply to provide even greater protection against rescission or cancellation of coverage.
- Rescission is defined as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage that has only a prospective effect is not a rescission, nor is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage in a timely manner.
- The rules that apply to an intentional misrepresentation of a material fact apply to representations by the individual seeking coverage or a person seeking coverage on behalf of the individual. If an employer applies for coverage on behalf of its employees, for example, representations by the employer to the issuer of coverage are subject to the regulatory standards for fraud and intentional misrepresentation.
- An issuer of health care coverage proposing to rescind coverage under the new standards must provide at least 30 calendar days advance notice to any individual whose coverage it seeks to rescind. This provides an opportunity to individuals and plan sponsors to explore their rights to contest the rescission or to look for alternative coverage.
- The rules concerning rescissions and advance notice apply to all grandfathered health plans.

### **Choice of Health Care Professional**

For plan years beginning on or after September 23, 2010, group health plans and group health insurance coverage must (i) allow designation as a primary care physician any participating primary care provider who is available to accept the participant; (ii) allow designation of a pediatrician as the primary care physician for any child; and (iii) allow any female enrollee to obtain obstetrical or gynecological care by any in-network OB/GYN without authorization or referral by the plan, health insurance issuer or primary care provider.

- These requirements only apply to a plan or health insurance coverage with a network of providers.
- A group health plan or group health insurance issuer must treat provision of obstetrical or gynecological services

itself as satisfaction of any requirement for authorization for such services by the primary care provider. The interim final regulations, however, do not prevent a group health plan or group health insurance issuer from requiring that the OB/GYN notify the primary care provider or the plan or issuer of treatment decisions.

- Group health plans and group health insurance issuers must provide notice to participants of these rights whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits. The interim final regulations provide model language for these notices.
- These requirements do not apply to grandfathered health plans.

### **Emergency Services**

For plan years beginning on or after September 23, 2010, a group health plan or group health insurance coverage that provides any benefits for emergency services must do so without the individual or health care provider having to obtain prior authorization (including prior authorization in order to be eligible for a higher level of coverage) and without regard to whether the emergency services are furnished by an in-network provider.

- Coverage for the emergency services must be provided without regard to any restriction other than the exclusion or coordination of benefits, a permissible affiliation or waiting period, or applicable cost-sharing requirements. No administrative requirement or limitation may be imposed for out-of-network emergency services that is more restrictive than the requirements or limitations applied to in-network emergency services.
- Cost-sharing requirements expressed as a co-payment amount or co-insurance rate on out-of-network emergency services cannot exceed corresponding requirements for in-network emergency services. Out-of-network providers are permitted, however, to bill patients for the difference between their charges and the amount collected from the group health plan or group health insurance issuer.
- The group health plan or group health insurance issuer must pay a reasonable amount for emergency services before a patient becomes responsible for a balance billing amount. This requirement is met if the plan or issuer provides benefits for out-of-network emergency services at least equal to the greatest of (i) the amount negotiated with in-network providers for emergency services; (ii) the amount for emergency services calculated using the same method the plan generally uses for out-of-network services (e.g., total charges eligible for payment determined based on usual, customary and reasonable charges), but substituting the in-network cost-sharing provisions for the otherwise applicable out-of-network cost-sharing provisions (e.g., if in-network cost-sharing is 80/20, and out-of-network cost-sharing is 50/50, this amount must be calculated using the more favorable 80/20 cost-sharing); or (iii) the amount that Medicare would pay for emergency services. The interim final regulations provide details and refinements for determining the first two of these three amounts.
- Any other cost-sharing requirement for emergency services may be imposed for out-of-network emergency services only if the requirement applies generally to out-of-network benefits. For example, a deductible may be imposed for out-of-network emergency services only as part of a deductible that applies generally to out-of-network benefits.
- Emergency services and related terms are defined generally by reference to the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, with minor variances.
- These requirements do not apply to grandfathered health plans.

If you have questions or would like additional information about these new coverage requirements under the Health Care Reform Law, please feel free to contact Brian Dougherty at (215) 587-5919 or [bdougherty@postschell.com](mailto:bdougherty@postschell.com).

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