CLIENT BULLETIN

Health Care Reform Regulations Posted on "Preexisting Condition Exclusions," "Lifetime and Annual Limits," "Rescissions" and "Patient Protections"

Regulations Allow 3-Year Phase-In of Restricted Annual Limits

---

On June 22, 2010, the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (IRS) jointly posted a pre-publication copy of ***Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections.*** The pre-publication version is available by "*clicking here*" or at: *http://www.federalregister.gov/inspection.aspx*. These regulations are scheduled to be published in the *Federal Register* on June 28, 2010 (The underlying health reform laws are collectively referred to as "*The Affordable Care Act.*").

A *Fact Sheet* entitled *The Affordable Care Act's New Patient's Bill of Rights* was also released and is available by "*clicking here*" or at:
http://www.healthreform.gov/newsroom/new_patients_bill_of_rights.html

A copy of just the ERISA set of regulations is available by "*clicking here.*" *Parallel regulations were issued by HHS and the IRS.*

A *Table of Provisions of the Affordable Care Act Applicable to Grandfathered Plans* is available by "*clicking here.*" When reading the Regulations and especially consumer-oriented items like the *Fact Sheet,* one must carefully discern whether the reform applies to grandfathered plans or not. The Table referenced above is a handy tool to print and keep for easy reference.

These interim final regulations are being published to implement rules on:

- prohibiting preexisting condition exclusions,
- prohibiting or limiting lifetime and annual dollar limits on benefits,
- limiting restrictions on rescission, and
- addressing reforms that do not apply to grandfathered plans (patient protections).

Prepared for TIC by Mike Ewing, J.D.
Director of Research
United Actuarial Services, Inc.
(317) 580-8659 • Fax (317) 580-8651
email: mewing@unitedactuarial.com
© United Actuarial Services, Inc. 2010

These Rules are applicable to grandfathered and non-grandfathered plans including collectively bargained plans beginning on or after September 23, 2010 – January 1, 2011 for calendar year plans.

The following discussion is drawn from the *Preamble* to the regulations. We will concentrate on the regulations as they apply to group health plans. The rules generally apply to health insurance issuers of group and individual policies too.

Prohibiting Preexisting Condition Exclusions

The *Affordable Care Act* provision prohibits any preexisting condition exclusion from being imposed by group health plans. This prohibition is generally effective with respect to plan years beginning on or after January 1, 2014.

However, for participants who are *under 19 years of age*, this prohibition becomes effective for plan years beginning on or after September 23, 2010, which is January 1, 2011 for calendar year plans and applies to grandfathered plans, including collectively bargained plans at the same times.

Until the new *Affordable Care Act* rules take effect, the *HIPAA* rules regarding preexisting condition exclusions continue to apply.

Prohibiting or Limiting *Lifetime* And *Annual* Dollar Limits

The statute prohibits annual limits on the dollar value of benefits generally, but allows "*restricted annual limits*" with respect to essential health benefits for plan years beginning before January 1, 2014. In addition, the statute provides that, with respect to benefits that are not essential health benefits, a plan or issuer may impose annual or lifetime per-individual dollar limits on specific covered benefits.

However, these regulations DO NOT define the crucial phrase "essential health benefits". That will be defined in a later regulation.

Good-Faith Compliance Acceptable

For purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "*essential health benefits.*" For this purpose, a plan or issuer must apply the definition of essential health benefits consistently. For example, a plan could not apply both a lifetime limit to a particular benefit – thus taking the position that it was not an essential health benefit – and at the same time treat that particular benefit as an essential health benefit for purposes of applying the restricted annual limit.

Blanket Exclusions Not An Annual Or Lifetime Dollar Limit

The prohibitions DO NOT prevent a plan from excluding all benefits for a condition, but if any benefits are provided for a condition, then the requirements of the rule apply. Therefore, an exclusion of all benefits for a condition is not considered to be an annual or lifetime dollar limit.

Three Year Phase-In For Restricted <u>Annual Limits</u>

In order to lessen the potential for "premium" increases for all plans and policies, while at the same time ensuring access to essential health benefits, the regulations adopt a <u>three-year phased</u> approach for <u>restricted annual limits</u>. Under these regulations, annual limits on the dollar value of benefits that are "*essential health benefits*" <u>may not be less than</u> the following amounts for plan years beginning before January 1, 2014:

- For plan years beginning on or after September 23, 2010 but prior to September 23, 2011, **$750,000;**
- For plan years beginning on or after September 23, 2011 but prior to September 23, 2012, **$1.25 million**; and
- For plan years beginning on or after September 23, 2012 but prior to January 1, 2014, **$2 million**.

As these are minimums for plan years beginning **<u>before 2014</u>**, 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.

The minimum annual limits for plan years beginning before 2014 apply on an individual-by-individual basis. Thus, any overall annual dollar limit on benefits applied to families may not operate to deny a covered individual the minimum annual benefits for the plan year. The regulations clarify that, in applying annual limits for plan years beginning <u>before January 1, 2014</u>, the plan may take into account <u>only</u> "essential health benefits."

<u>Notice Required</u> to be Sent to Those Who Have Reached a Lifetime Limit Under the Plan and Special Enrollment Period

Individuals who <u>reached a lifetime limit</u> under a plan prior to the applicability date of these regulations and are <u>*otherwise still eligible*</u> under the plan or health insurance coverage **<u>must be provided with a *notice* that the *lifetime limit* no longer applies.</u>** If such individuals are no longer enrolled in the plan, the regulations also provide an enrollment opportunity for such individuals.

These notices and the enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Anyone eligible for an enrollment opportunity must be treated as a special enrollee. That is, they must be given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

Lifetime/Annual Limits Regulation's Effective Date

Regulations relating to the <u>prohibition on **lifetime** limits</u> *apply to all group health plans*, <u>whether or not the plan qualifies as a grandfathered health plan</u>, for plan years beginning on or after September 23, 2010.

The statute and the regulations relating to the prohibition on **annual** limits, including the *special rules regarding restricted annual limits* for plan years beginning before January 1, 2014, apply to group health plans that qualify as a grandfathered health plan.

Restrictions On Rescissions of Coverage

The regulation sets out rules regarding rescissions of health coverage for group health plans. A "rescission" is a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage with only a *prospective effect* is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Under the statute and the regulations, a group health plan must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. Under prior law, rescission may have been permissible if an individual made a misrepresentation of material fact, *even if the misrepresentation was not intentional or made knowingly*.

This standard applies to all rescissions, whether in the group or individual insurance market, and whether insured or self-insured coverage. These rules also apply regardless of any contestability period that may otherwise apply.

Existing Rules On Allowable Rescissions

According to the *Preamble*, the statute's and regulation's prohibition on rescissions should be read in light of the existing law which allows recession for:

- nonpayment of premiums;
- fraud or intentional misrepresentation of material fact;
- withdrawal of a product or withdrawal of an issuer from the market;
- movement of an individual or an employer outside the service area; or,
- for bona fide association coverage, cessation of association membership.

Notice Requirement Of Restrictions On Recessions

These regulations provide that a group health plan 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.

Patient Protections – Reforms That DO NOT Apply To Grandfathered Plans

The regulations also address reforms that DO NOT apply to grandfathered plans:

- choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician;
- obtain obstetrical or gynecological care without prior authorization.
- plan 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.

Concluding Thought

Trustees and Plan professionals now have more guidance on the roadmap to compliance. Since collectively bargained plans do not have a delayed effective date for many reforms, the regulations provide help in determining what amendments must be made to the health plan to bring it into compliance and also provides valuable help in the new notice requirements on rescissions and annual/lifetime limits. Hopefully, the regulations defining "essential health benefits" will be issued soon and fill-in a vital, missing piece of the puzzle. We will keep you updated as new information is posted.

* * *

LEGAL DISCLAIMER: Information contained in this publication is not legal advice, and should not be construed as legal advice. If you need legal advice upon which you can rely, you should seek a legal opinion from your attorney.