

Preexisting Condition Exclusions, Rescissions, Lifetime and Annual Limits, Patient Protections, and Preventive Care

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Background

Interim final regulations were released by the U.S. Departments of Treasury, Labor, and Health and Human Services detailing some of the provisions of the Patient Protection and Affordable Care Act (PPACA) on June 22, 2010. The released regulations state that the requirements relating to preexisting condition exclusions, rescissions, and lifetime and annual limits are applicable to all group health plans, including grandfathered plans. However, the rules relating to patient protections and preventive services are not applicable to grandfathered plans. Detailed below is a summary of the guidance released by the departments with regards to the specific topics:

Preexisting Condition Exclusions

The new regulations state that for plans renewing on or after September 23, 2010, group health plans are prohibited from denying coverage to dependents or enrollees under the age of 19 based on a preexisting condition. The regulations define a preexisting condition exclusion as a benefit limitation or outright coverage denial based on the fact that the condition was present before the effective date of group health plan coverage.

It is important to note that this does not include a benefit limitation or coverage denial that would apply regardless of the effective date of group coverage.

Regulations within PPACA call for the prohibition of preexisting condition exclusions for all covered individuals, beginning for plan years effective on or after January 1, 2014.

Arbitrary Rescissions of Insurance Coverage

Under the new regulations, plans with an effective date on or after September 23, 2010 will be prohibited from rescinding health coverage except in the case of fraud or an intentional misrepresentation of material facts, regardless of grandfathered status. The regulations define a policy rescission as a retroactive cancellation or discontinuance of an individual's policy by the plan or insurer.

It is important to note that this does not prohibit a cancellation or discontinuance that occurs prospectively. It also does not apply to a retroactive termination of coverage due to a failure to pay premiums or contributions towards the cost of coverage.

In cases where the rescission of coverage is allowed under the regulations, insurers and plans must provide at least 30 days advance notice of rescinded coverage to all affected participants to offer appropriate appeal time.

Lifetime and Annual Coverage Limits

Under the new regulations, plans are prohibited from issuing lifetime or annual limits on the dollar value of "essential health benefits." The new regulations apply to all group health plans, regardless of their grandfathered status, for plan dates effective on or after September 23, 2010. The annual and lifetime limit regulations set forth in PPACA apply only when coverage is provided for a certain condition – the regulations do not affect plans that exclude covering certain services.

The regulations specify that while lifetime limits will be prohibited from the initial effective date, the annual limits prohibition will be phased in, using restricted limits until January 1, 2014. Thus, for plan years with effective dates on or after September 23, 2010, all lifetime maximum amounts for benefit coverage will be banned. Annual limits will be restricted according to the following schedule:

- \$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
- \$2 million for plan years beginning on or after September 23, 2012, but before September 23, 2013

For an individual who reached a lifetime maximum benefit level before the new regulations went into place, the regulations state that the plan is required to give the individual a written notice that the lifetime limit no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. Further, if the individual has dropped enrollment, he has 30 days to re-enroll. A link to the sample notice released by the DOL can be found at the end of this document.

The HHS has also announced that they may establish a program under which a waiver may be provided to plans with non-compliant annual limits if compliance with the annual limit requirements would result in a significant decrease in access to plan benefits or a significant increase to premiums.

The “Essential Health Benefits” defined under PPACA include, but are not limited to:

- Ambulatory patient services and emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription Drugs
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Further guidance on “essential health benefits” has yet to be issued. Until this is done, for any plan years that begin before guidance is issued, regulators will take into account consistent and good faith efforts to comply with the interpretation of “essential health benefits.”

Patient Protections

Under the new regulations, there are requirements relating to the choice of healthcare providers and benefits and cost-sharing for emergency services. The new protection regulations apply for plan years effective on or after September 23, 2010, for group health plans. Grandfathered plans are exempt from the patient protection regulations.

Choice of Healthcare Provider

The regulation on choice of a healthcare provider applies to all plans that have negotiated with healthcare providers. For plans in which a participant must designate a participating primary care provider, the plan or insurer must permit the individual to designate any participating primary care provider who is available to accept the individual. This also applies to dependents of participants – the plan or insurer must permit the designation of a pediatrician as a child’s primary care provider if the provider participates in the network of the plan and is available to accept the child. For plans that offer coverage of obstetrical or gynecological care, plans or insurers may not require authorization or referral by the plan, insurer, or any person for a female participant (or covered family member) who seeks obstetrical or gynecological care.

It is important to note, however, that nothing precludes the plan or insurer from requiring an in-network obstetrical or gynecological provider to adhere to policies and procedures regarding referrals, prior authorization of treatments, and the provision of services pursuant to a treatment plan approved by the plan or insurer.

The regulation also notes that plans must notify employees of this provision. A link to the sample notice released by the DOL can be found at the end of this document.

Emergency Services

A plan or insurer providing emergency services must do so without the individual or provider having to obtain prior authorization, and without regard to whether the emergency health care provider is an in-network provider. The plan is prohibited from imposing any administrative requirements or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network services.

The regulations also impose requirements on cost-sharing for emergency services. Copayments or coinsurance requirements for out-of-network coverage cannot exceed the requirements for in-network coverage. However, a participant may be required to pay the excess of the amount of the out-of-network charges over the amount the plan or insurer is required to pay (known as “balanced billing”), provided that the plan pays a reasonable amount. The “reasonable amount” is defined in the regulations as the greatest of three amounts:

1. The amount negotiated with in-network providers for the given emergency service
2. The amount for the emergency service calculated using the same method the plan generally uses to determine payment for out-of-network services, but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions
3. The amount that would be paid under Medicare for the emergency service.

Preventive Care Services

Under the new regulations, there are requirements relating to health plans providing a wide array of preventive care services and items at no cost-sharing to the employee. The new protection regulations apply for plan years effective on or after September 23, 2010, for group health plans. Grandfathered plans are exempt from the preventive care mandates.

The interim final rule indicates that the following preventive care services must be provided to the applicable plan members without cost-sharing:

- Evidence-based items or services that have in effect an A or B rating in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved. A list of these items and services is included in the links below.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CBC Advisory Committee) with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA. Health and Human Services will be developing these guidelines, and they are expected to be issued by August 1, 2011.

The interim final rules do offer some specific additional remarks while following the above guidelines. If a plan has a network of providers, the above requirements do not apply to out-of-network providers. The employer may decide to exclude the benefits or impose cost-sharing requirements if the service occurs out-of-network. The rules also say that if a recommendation (mentioned in the above conditions) does not specify a frequency, method, treatment, or setting for a service, the plan may use “reasonable medical management techniques” to determine coverage limitations.

The regulation also presents rules for cost-sharing with regards to preventive care services that are provided during an office visit:

- Given a provider who tracks a preventive care service and bills it separately from an office visit, then the plan is permitted to impose cost-sharing requirements for the visit.
- Given a provider who does not bill preventive care services separately from an office visit, there are two possible scenarios. If the primary purpose of the office visit was to receive the required preventive care service, cost-sharing is not permitted to apply to the office visit. However, if the primary purpose of the office visit was not to receive a preventive care service but one occurred, then the plan is permitted to impose cost-sharing requirements for the visit.

Please note that if a particular service is revoked by the agencies that determine the above preventive services, plans are no longer required to offer the service at a plan cost of 100%. However, if this is the case, the plan will be required to provide enrollees with a notice at least 60 days prior to the change, detailing the change of service.

U.S. Department of Health & Human Services Resource Links:

Interim Final Regulations
Preexisting Conditions, Limits, Rescissions, and Patient
Protections: <http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf>

Preventive:
<http://edocket.access.gpo.gov/2010/pdf/2010-17242.pdf>

Government Fact Sheet:
http://www.healthreform.gov/newsroom/new_patients_bill_of_rights.html

Lifetime limits model notice:
<http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc>

Patient protection model notice:
<http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc>

U.S. Preventive Services Task Force Recommendations (A
and B Rated Services):
<http://www.healthcare.gov/center/regulations/prevention/taskforce.html>

For more information on healthcare reform and guidance
on grandfathered plans, please contact
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