

June 28, 2010

PPACA Rules on Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions of Coverage, and Patient Protections Issued

On June 22, 2010, the tri-agency task force¹ charged with drafting regulations under the Patient Protection and Affordable Care Act (PPACA) released [interim final regulations](#) regarding PPACA's rules on preexisting condition exclusions, lifetime and annual limits on benefits, rescissions, and patient protections related to the selection of healthcare providers and access to emergency care. The task force also released a [Fact Sheet](#) summarizing the regulations.

The interim final regulations are scheduled for publication in the Federal Register on June 28, 2010 and are generally applicable for plan years beginning on or after September 23, 2010, with certain exceptions. This Legal Alert highlights the guidance set forth in the regulations.

Preexisting Condition Exclusions

PPACA amends the Public Health Service Act (PHSA) to add section 2704, which prohibits group health plans offering group or individual coverage from imposing any preexisting condition exclusions. The rule expands the current restrictions under the Health Insurance Portability and Accountability Act (HIPAA) on preexisting condition exclusions, which do not apply to individual health insurance coverage and permit limited preexisting condition exclusions under some circumstances.

HIPAA generally defines a preexisting condition exclusion as a limitation on, or exclusion of, benefits relating to a condition because the condition was present before the enrollment date for coverage. The PPACA regulations prohibit not only an exclusion of specific benefits associated with a particular condition, but also prohibit a complete denial of coverage under a plan or policy due to a preexisting condition. The regulations leave unchanged the HIPAA rule that a plan may completely exclude coverage for a particular condition if the exclusion applies regardless of when the condition arose.

The prohibition on preexisting condition exclusions is generally effective for plan years beginning on or after January 1, 2014; however, with respect to enrollees under age 19, the prohibition is effective for plan years beginning on or after September 23, 2010. Also, the prohibition applies to grandfathered group health plans. See our June 16, 2010 [Legal Alert](#) for more information on the grandfathering rules under PPACA.)

¹ These agencies are the Internal Revenue Service, the Department of Treasury, the Employee Benefits Security Administration of the Department of Labor, and the Department of Health and Human Services Office of Consumer Information and Oversight.

Lifetime and Annual Limits

General Rule

Section 2711 of the PHSAs, as added by PPACA, prohibits group health plans from imposing annual or lifetime limits on the dollar value of “essential health benefits.” The regulations provide certain exceptions and clarifications with respect to this rule:

- The rule does not apply to health flexible spending arrangements, medical savings accounts, or health savings accounts.
- If a health reimbursement arrangement (HRA) is integrated with other coverage as part of a group health plan, and the other coverage standing alone would comply with this rule, then the HRA will not be subject to the rule.
- The rule generally does not apply to retiree-only stand-alone HRAs. The tri-agency task force has requested comments regarding the application of the rule to non-retiree-only stand-alone HRAs.
- The regulations clarify that the rule does not preclude a plan from excluding all benefits with respect to a particular condition. If the plan provides any benefits for a condition, however, the rule applies.

Additionally, a plan may impose annual or lifetime per-individual dollar limits on specific covered benefits that are not essential health benefits. The regulations define essential health benefits by reference to section 1302(b) of PPACA and the applicable regulations. Because regulations have not yet been issued under section 1302(b) of PPACA, the preamble to the regulations says that plans should make a good faith effort to comply with a reasonable definition of “essential health benefits” until regulations defining this term are issued.

Restricted Annual Limits Permitted for Plan Years before January 1, 2014

PPACA allows plans to impose some annual limits, called “restricted annual limits,” on essential health benefits for plan years beginning before January 1, 2014. Under the new regulations, the restricted annual limits are permissible under a phased approach and may not be less than the following amounts:

- \$750,000 for plan or policy years beginning on or after September 23, 2010 but before September 23, 2011;
- \$1.25 million for plan or policy years beginning on or after September 23, 2011 but before September 23, 2012; and
- \$2 million for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014.

Because these are minimums, a plan may choose to impose a higher limit or no limit for a plan year. In determining whether the restricted annual limit for a plan or policy year has been reached, the plan may take into account only essential health benefits. Additionally, the restricted annual limits apply on an individual basis.

In response to concerns that the restricted annual limit minimums could adversely impact participants in limited benefit and “mini-med” plans, the regulations direct the Secretary of Health and Human Services (HHS) to implement a program under which these requirements may be waived if compliance would result

in a significant decrease in access to benefits or a significant increase in premiums. HHS guidance describing the waiver application process is expected in the near future.

Notice and Enrollment Requirements

If an employee's past claims have exceeded the plan's lifetime limit, but the employee is otherwise still eligible for coverage under that plan, the regulations require that the plan inform the employee that the lifetime limit no longer applies. If the employee is no longer enrolled in the plan, the regulations require the plan to offer the employee an enrollment opportunity as a special enrollee. Thus, the employee must be given the opportunity to enroll in all of the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, the regulations provide that any difference in benefits or cost-sharing requirements constitutes a different benefit package. The notice and enrollment opportunity must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010, and coverage must begin as of that date. The enrollment opportunity must last at least 30 days.

The prohibition on lifetime limits and the annual limit restrictions apply to grandfathered group health plans.

Coverage Rescissions

Prior to the enactment of PPACA, a plan could potentially rescind coverage for an employee's unintentional or inadvertent misrepresentations regarding health status or preexisting conditions. Under PPACA, however, group health plans (including grandfathered arrangements) may not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. The regulations clarify the PPACA rules on rescissions:

- The rules apply regardless of whether the rescission would affect an individual with single coverage, an individual within a family, or an entire group of individuals.
- The rules apply to representations made by the individual or a person seeking coverage on behalf of the individual. For example, the rules apply to representations made by a plan sponsor while seeking coverage for an employment-based group.
- A plan or policy is permitted to rescind coverage based on an omission to the extent that the omission constitutes fraud.
- If a rescission is permissible, the plan must provide at least 30-days' notice before rescinding coverage.

Because the regulations define rescission as a cancellation or discontinuance of coverage that has a retroactive effect, they do not restrict a prospective cancellation of coverage (although such a cancellation would be restricted by other federal laws, including other sections of the PHSA, and possibly state laws). The regulations further provide that a retroactive cancellation of coverage is not a rescission if it is attributable to a failure to pay required premiums.

Patient Protections

Section 2719A of the PHSA imposes requirements on plans with respect to (i) an individual's choice of healthcare professionals (for plans with a provider network) and (ii) benefits for emergency services. Grandfathered plans are exempt from both sets of requirements.

Choice of Healthcare Professionals

Two of the requirements under section 2719A of the PHSA and the regulations govern a participant's right to choose a primary care provider. If a group health plan requires or permits a participant to designate a participating primary care provider, then the plan must permit the participant to select any participating primary care provider that is available to accept him or her. Additionally, if a plan requires or permits a participant to designate a participating primary care provider for a child, the plan must permit the participant to designate a pediatrician as the child's primary care provider if the pediatrician participates in the plan network and is available to accept the child.

The PHSA and the regulations also expand the ability of female participants to choose a provider for obstetrical and gynecological care. Generally, a plan may not require that a female participant seeking obstetrical or gynecological care by an in-network specialist first obtain the authorization of, or a referral from, her primary care provider or the plan. The plan may, however, require an obstetrical or gynecological care provider to comply with its referral and treatment authorization policies.

The regulations further require a plan to provide participants with a notice describing their rights under each of these rules, as applicable. This notice must be made part of the summary plan description or other description of benefits. The regulations include model language that may be used in drafting the notice.

Emergency Services

In an effort to provide participants with equal access to in-network and out-of-network emergency services, the PHSA and the regulations contain detailed coverage and cost-sharing requirements applicable to emergency benefits. Under the regulations, a plan must provide coverage for emergency services without regard to whether the provider is in-network or out-of-network and cannot require the individual or healthcare provider to obtain prior authorization. A plan also may not impose administrative requirements or benefit limitations for out-of-network emergency services that are more restrictive than those applicable to in-network services. In addition, cost-sharing requirements expressed as a copayment or coinsurance rate for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed for in-network emergency services.

Despite these cost-sharing protections, nothing in the regulations prevents an out-of-network healthcare provider from balance billing a patient for the difference between the provider's charges and the amount collected from the patient and the plan. However, in order to avoid having a plan rely on balance billing to avoid paying a reasonable portion of out-of-network charges, the regulations require a plan to pay a specified minimum amount with respect to an out-of-network emergency service. Specifically, the regulations state that a plan must provide benefits for out-of-network emergency services in an amount equal to the greatest of:

- The amount negotiated with the plan's in-network providers for the emergency service furnished (using the median of the negotiated amounts if more than one exists), excluding any in-network copayment or coinsurance imposed with respect to the individual;
 - The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable rate), excluding any in-network copayment or coinsurance imposed with respect to the individual;
- or

- The amount that would be paid under Medicare for the service, excluding any in-network copayment or coinsurance imposed with respect to the individual.

This rule ensures that the plan pays a “reasonable share” of any out-of-network emergency benefits regardless of the plan’s method for determining in-network and out-of-network rates.

The preamble provides for a 60-day comment period on the regulations, ending September 28, 2010.



If you have any questions about this Legal Alert, please feel free to contact the attorneys listed below or the Sutherland attorney with whom you regularly work.

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