GROOM LAW GROUP

MEMORANDUM

June 29, 2010

RE: Agencies Issue Interim Final Rule On Pre-existing Condition Exclusions, Annual & Lifetime Limits, Rescission, Choice Of Providers, And Emergency Services

On June 28, 2010, the Departments of Health and Human Services, Labor, and Treasury published a new Interim Final Rule (or Regulation) addressing several provisions of the Patient Protection and Affordable Care Act (PPACA). 75 Fed. Reg. 37188 (June 28, 2010). The new Regulation includes requirements related to preexisting condition exclusions, annual and lifetime dollar limits, rescissions, choice of providers, and coverage of emergency services. Comments are due by August 27, 2010. Except where noted, most of the requirements in the new Regulation are applicable 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 year plans).

Below we summarize the statutory requirements under PPACA in these areas and any additional requirements or guidance provided by the Regulation.

Pre-Existing Condition Exclusions

- PPACA Statutory Requirement – The statute requires that group health plans and health insurance issuers offering coverage to individual or group health plans may not impose a pre-existing condition exclusion (PCE) on enrollees under age 19 for plan years beginning on or after September 23, 2010. This requirement extends to all individuals covered under the plan for plan years beginning on or after January 1, 2014.

- Applicability – The Regulation applies to grandfathered and non-grandfathered plans and applies to self-funded and insured plans (individual and group coverage).

- Regulation - The Regulation restates the PPACA rule. However, the Preamble notes that an exclusion for a particular benefit will be permitted if it applies regardless of when the condition arose relative to the effective date of coverage.

> *Example from Regulation: A policy that excludes benefits for oral surgery related to a traumatic injury that occurred 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.*

- Definition of Pre-Existing Condition Exclusion – The Regulation revised the definition of PCE (from prior HIPAA regulations) to mean a limitation or exclusion of benefits, "including a denial of coverage," based on the fact a condition was present before the effective date of coverage "or if coverage is denied, the date of the denial." This revision appears to extend the existing PCE rules beyond an exclusion for a particular benefit to eligibility for coverage as a whole.

The definition also says a PCE 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 the individual, or review of medical records relating to the pre-enrollment period." The quoted language is new and possibly could impact health risk assessments and wellness program screenings.

Example from Regulation: An insurer denies coverage under a policy based on a pre-enrollment physical that reveals that the applicant has Type 2 diabetes. The example says this denial of coverage is based on the fact that a condition was present before the date of denial, so is a PCE that is not permitted.

Annual / Lifetime Limits

- PPACA Statutory Requirement – The statute requires that group health plans and health insurance issuers offering coverage to individual or group health plans may not impose an annual or lifetime dollar limit on essential benefits, as defined in PPACA. The statute allows the Secretary to permit "restricted annual limits" prior to 2014 to ensure that "access to needed services is made available with a minimal impact on premiums."

- Applicability – 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 and new individual policies. Grandfathered individual policies can still impose annual limits.

- Regulation – The Regulation provides that, except for the restricted annual limits below, a health plan may not impose an annual or lifetime dollar limit on "essential benefits." It appears that the Regulation applies to the total dollar limit and does not extend the requirement to specific treatment limits (such as day or visit limits) or per procedure dollar limits.

- Essential Health Benefits - The Regulation does not define "essential health benefit" beyond the following categories that are listed in PPACA:

  - 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.

Until further guidance is issued more fully defining these categories, the Preamble says the agencies will take into account "good faith efforts" to comply with a "reasonable interpretation" of the term "essential health benefits." The Preamble states that plans must apply the definition of "essential health benefits" on a consistent basis for purposes of applying the lifetime and annual limit restrictions.

- Restricted Annual Limits – In what the agencies characterize as a "three-year phased approach," the Regulation provides that, prior to 2014, a plan may establish an annual limit on the dollar amount of benefits that are essential, provided the limit is at least:

  - $750,000 for the 2011 Plan Year (which begins on or after 9/23/10, but before 9/23/11);

  - $1.25 million for the 2012 Plan Year (which begins on or after 9/23/11, but before 9/23/12); and

  - $2 million for the 2013 Plan Year (which begins on or after 9/23/11, but before 1/1/14).

  The Preamble specifies that these limits must apply on an individual-by-individual basis (so cannot be applied to a family as a whole). The Regulation does not specify whether a plan would be able to apply benefit-specific annual limits (for example, $200,000 annual limit on maternity care), totaling the annual maximum allowed, or if plans only may have one overall annual limit. The Regulation says that a plan may continue to exclude "all benefits for a condition." However, if "any benefits" are provided for a condition, then the requirements apply.

- Re-Enrollment for Participants Who Previously Reached Maximum – When an individual already has reached a lifetime maximum, plans must provide an opportunity to re-enroll in coverage. The one-time re-enrollment right is similar to the re-enrollment right under the new dependent rules allowing coverage to age 26. The re-enrollment period must extend at least 30 days and begin no later than the effective date of the requirement (January 1, 2011 for calendar year plans). The plan must provide written notice that the lifetime limit no longer applies and that the individual is once again eligible for benefits (the Department of Labor has issued a model notice for both this re-enrollment right and the age 26 re-enrollment right). The notice may be provided to the employee on behalf of any dependents or may be included with other enrollment materials, as long as it is "prominent." 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 (as under HIPAA and the age 26 rules, if the enrolling individual is not the employee or subscriber, the employee or subscriber also may be eligible to enroll or change benefit options). The Preamble states that the re-enrollment right does not apply in the individual market where a contract has not been

renewed or otherwise is no longer in effect. However, the requirement would apply if the policy is still in force, such as where a family member may have reached the lifetime limit.

- Applicability to Account-Based Plans – The Regulation states that the new annual/lifetime limit rules are not applicable to a health flexible spending account (health FSA). The Preamble clarifies that the rules also are not applicable to medical savings accounts (MSAs) or health savings accounts (HSAs).

  The Preamble says that the rule is not applicable to a health reimbursement arrangement (HRA) that is "integrated with other coverage," where the other coverage alone would comply with the annual/lifetime limit requirements. The Preamble says the fact that benefits under the HRA are limited does not violate the rule because the combined benefit satisfies the requirements. The Preamble says that retiree-only HRAs also are not subject to the rule due to the "retiree-only" exception discussed in the Preamble to the grandfather rules (related to the small employer exception found in ERISA and the Code). The agencies requested comments as to whether the annual/lifetime limits rule should apply to stand-alone non-retiree HRAs.

- Application for Waiver (Limited Benefit Plans) – The Regulation provides that, before January 1, 2014, the Secretary may establish a program to waive annual limits for a plan that has annual dollar limits below the restricted annual limit amounts above if compliance with the new limits "would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage." The Preamble indicates that HHS will issue guidance on the application process in the "near future." According to the Preamble, the waiver program would be established so that individuals with certain coverage, including coverage under a limited benefit or so-called "mini-med" plans, would not be denied access to needed services or experience more than a minimal impact on premiums.

Rescission of Coverage

- PPACA Statutory Requirement – The statute requires that a group health plan or health insurance issuer offering coverage to individual or group health plans could not rescind coverage with respect to an enrollee except where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage. The statute also provides that a plan may cancel coverage only with prior notice to the enrollee and only as permitted under certain exceptions to the HIPAA guaranteed renewability rules (nonpayment of premium, fraud, violation of participation or contribution rules, termination of plan, movement outside service area, and association membership ceasing).

- Applicability – The Regulation applies to grandfathered and non-grandfathered plans and applies to self-funded and insured plans (individual and group coverage).

- Regulation – The Regulation provides that a plan may not rescind coverage (either group or individual) once an individual is covered under the plan, unless the individual or person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud or makes an *intentional* misrepresentation of material fact, as prohibited by terms of the plan.

> *Examples from Regulation:*
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> *An individual completes a medical questionnaire regarding prior history, which affects the group rate. The individual fails to list two visits to a psychologist six years previously. The individual is later diagnosed with breast cancer. The plan cannot rescind the individual's coverage due to failure to disclose the psychologist visits because this was an "inadvertent" failure and not fraudulent or an intentional misrepresentation of material fact.*
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> *A plan provides coverage to full-time employees. Jack is covered as a full-time employee, but is reassigned to a part-time position. Under the plan terms, Jack no longer is eligible for coverage. The plan mistakenly continues to provide coverage, collecting premiums and paying claims. After a routine audit, the plan discovers that Jack no longer is considered a full-time employee. The plan rescinds Jack's coverage to the date Jack was reassigned to part-time employment. The plan cannot rescind coverage because there was no fraud or misrepresentation of material fact. The plan only may cancel coverage prospectively.*

- Definition of Rescission – The Regulation defines "rescission" as a cancellation or discontinuance of coverage that has a retroactive effect. The Regulation states that a rescission would include a cancellation that treats a policy as void from the time of the individual's or group's enrollment or that voids benefits up to a year before cancellation. The Regulation clarifies that a cancellation will not be considered a rescission if it is prospective or only is effective retroactively to extent attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

- Prior Notice - The plan must provide 30 days advance written notice to each participant affected, regardless of whether coverage is insured or self-insured and regardless of whether the rescission applies to the entire group or only an individual within the group (so it appears that notice just to the employer group would not suffice). The Preamble says the 30-day period will give individuals and plan sponsors the "opportunity to explore their rights to contest the rescission, or look for alternative coverage, as appropriate."

- Future Guidance on Cancellations - The Regulation only addresses rescissions, not cancellations. The Preamble says the agencies expect to issue future guidance on any notice requirements for cancellations other than rescission.

Patient Protections: Choice of Providers

- PPACA Statutory Requirement – The statute generally requires that group health plans and health insurance issuers offering coverage to individual or group health plans must

allow an individual to choose his or her 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.

- Applicability – The Regulation only applies to non-grandfathered plans and only applies where the plan uses a network of providers. The Regulation applies to both self-funded and insured non-grandfathered plans (group and individual coverage).

- Regulation: Primary Care Provider (PCP) - If a plan requires a participant to designate a PCP, the plan must permit each participant to designate "any participating primary care provider who is available to accept" the participant. The Regulation states that the plan may designate a default PCP until the individual has designated a PCP of his or her own.

- Regulation: Pediatrician - If plan requires child to designate a primary care provider, the plan must permit the child to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's PCP if the provider participates in the plan's network and is available to accept the child.

- Regulation: OB-GYN – A plan may not require a woman to obtain an authorization or referral to obtain coverage by a participating health care professional specializing in obstetrics or gynecology. This would include any individual (including a non-physician) who is authorized under applicable state law to provide obstetrical or gynecological care. The requirement does not apply to a nonparticipating (out-of-network) professional. However, the plan may require the provider to otherwise adhere to the plan's policies and procedures regarding further referrals or authorizations. In addition, the plan may still require the individual to notify their primary care provider or the plan.

  Example from Regulation: A plan requires participants to designate a PCP and requires prior authorization before providing benefits for uterine fibroid embolization. The plan would not be able to require prior authorization for a female to see a participating OB-GYN, but would be permitted to require prior authorization before providing benefits for the uterine fibroid embolization procedure.

- Notice of Rights to Choose Provider – A plan that requires designation of a PCP must provide notice informing each participant of the plan terms regarding such designation, including the right to select a PCP, pediatrician, or health care professional specializing in obstetrics or gynecology. The notice must be included with the summary plan description or other similar description of benefits under the plan. The Regulation includes model language.

Patient Protections: Emergency

- PPACA Statutory Requirement – The statute generally requires that group health plans and health insurance issuers offering coverage to individual or group health plans must cover emergency services (as defined in PPACA) without prior authorization and regardless of whether the service was provided in-network or out-of-network.

- Applicability – The Regulation applies to both insured and self-funded plans, but only applies not non-grandfathered plans.

- Regulation - If a plan provides any benefits with respect to services in an "emergency department of a hospital," the plan must cover emergency services as follows:

  - without the need for prior authorization, regardless of whether the service is provided in-network or out-of-network (but the plan may require notification);

  - without regard to whether the service is furnished by participating provider;

  - without imposing any administrative requirement or limitation on coverage that is more restrictive for out-of-network services than in-network services;

  - in compliance with the cost-sharing requirements below; and

  - without regard to any other term or condition other than an exclusion for benefits, coordination of benefits, waiting periods, or applicable cost sharing.

- Cost Sharing Requirements for Deductibles & Out-of-Pocket Maximums – The Regulation states that the plan may impose a deductible or out-of-pocket maximum with respect to out-of-network coverage if the deductible or out-of-pocket maximum applies to all out-of-network benefits generally (not just emergency services).

  Example from Regulation: 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 care. 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 (that 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.

- Cost Sharing Requirements for Copayments & Coinsurance – If a participant obtains emergency services out-of-network, a plan only may charge the copayment or coinsurance applicable to in-network emergency services and must provide benefits equaling the greater of three amounts: (1) the median of negotiated in-network rates; (2) the generally applicable out-of-network cost; or (3) the Medicare rate. A provider may "balance bill" over the amount the plan is required to pay.

  The plan must pay the greater of the following amounts:

  Amount 1: **Median of Negotiated In-Network Rates** – The median of the amount negotiated with each in-network provider (excluding any copayment/coinsurance). If the plan does not negotiate this rate (such as under a capitation agreement), this amount is disregarded, and the plan looks only to amounts under #2 and #3 below. Note: The median is

determined by listing the numbers in order and taking the middle number. If there is no middle number, the median is the average of the two middle numbers.

Example: A plan pays 80% of the agreed amount of in-network emergency services and 50% on the UCR amount for non-network services, with the following negotiated rates with its network providers (different negotiated rates with different providers): $85, $100, $100, $110, $110, $120, $120, $120, $150. The median is $110. ***Amount 1 is 80% of $110 (median), or $88.***

Amount 2: **Out-of-Network Calculation / UCR** – The amount the plan generally uses to determine payment for out-of-network services, such as the usual, customary, and reasonable (UCR) amount (excluding any copayment/coinsurance).

Example: A plan pays 80% of the agreed amount of in-network emergency services and 50% on the UCR amount for non-network services. UCR for emergency services is $116. ***Amount 1 is 80% of $116 (UCR), or $92.80.***

Amount 3: **Medicare Rate** – The amount that would be paid under Medicare Parts A or B (excluding any copayment/coinsurance). According to the Preamble, these rates can be found at www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf.

Example: A plan pays 80% of the agreed amount of in-network emergency services and 50% on the UCR amount for non-network services. The Medicare rate for these services is $80. ***Amount 3 is 80% of $80 (Medicare Rate), or $64.***

In the above examples, the greater number is Amount 2 - $92.80. If a provider charges $125 for the service, the provider may balance bill $32.20 to the participant. The plan also may charge the 20% cost sharing rate for in-network care.

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If you have questions, please contact your regular Groom attorney or any of the attorneys listed below.

Jon W. Breyfogle	jwb@groom.com	(202) 861-6641
Jenifer A. Cromwell	jac@groom.com	(202) 861-6329
Kimberly M. Dahm	kdahm@groom.com	(202) 861-2606
Thomas F. Fitzgerald	tff@groom.com	(202) 861-6621

Cheryl Risley Hughes	chughes@groom.com	(202) 861-0167
Christine L. Keller	clk@groom.com	(202) 861-9371
Tamara S. Killion	tkillion@groom.com	(202) 861-6328
Mark Nielsen	mcn@groom.com	(202) 8615429
William F. Sweetnam	wfs@groom.com	(202) 861-5427
Christy A. Tinnes	cat@groom.com	(202) 861-6603
Brigen L. Winters	blw@groom.com	(202) 861-6618