AGENCIES ISSUE INTERIM FINAL REGULATIONS REGARDING BENEFIT LIMITS, PREEXISTING CONDITION EXCLUSIONS, RESCISSIONS OF COVERAGE, AND PATIENT PROTECTIONS

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On June 22, 2010, the Departments of the Treasury, Labor, and Health and Human Services ("Departments") jointly issued interim final regulations providing guidance regarding lifetime and annual dollar limits on benefits, preexisting condition exclusions, rescissions, and patient protections ("Interim Final Regulations").

The Interim Final Regulations are the fourth in a series providing guidance relating to group and individual market reforms modified and added by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (together, "PPACA"). The Interim Final Regulations are generally effective for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2010 for calendar year plans). Comments are requested within 60 days after publication in the Federal Register.

Highlights of the Interim Final Regulations include:

- A plan or issuer generally may not establish or maintain any annual or lifetime limit on the dollar amount of "essential health benefits" for any individual, unless qualifying "restricted" annual limits pre-2014. A plan or issuer may exclude all benefits for a condition; however, if any benefits are provided for a condition, then the prohibition regarding annual or lifetime limits applies.

- A plan or issuer may impose annual or lifetime dollar limits with respect to any individual on benefits that are not "essential health benefits" (to the extent that such limits are permitted under other applicable federal or state law).

- A plan or issuer is permitted to impose annual limits on "essential benefits" as low as $750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011; $1,250,000 for plan years beginning on or after September 23, 2011 but before September 23, 2012; and $2,000,000 for plan years beginning on or after September 23, 2012 but before January 1, 2014.

- The Secretary of Health and Human Services ("HHS") may waive the annual limit requirements for plan years beginning on or before January 1, 2014, if compliance with the restricted annual limits would result in a (i) significant decrease in access to benefits, or (ii) significant increase in premiums for the plan or coverage.

- Health flexible spending arrangements (as defined in section 106(c)(2)) ("health FSAs") are not subject to the prohibition on annual limits.

- Integrated health reimbursement arrangements ("HRAs") are excepted from the annual limits, as are retiree-only HRAs, but the treatment of stand-alone HRAs remains unclear.

- A plan or issuer must provide notice and a special enrollment period to individuals who are otherwise eligible for coverage but already "hit" the plan or policy's lifetime limit.

- A plan or issuer offering group health insurance coverage may not impose any "preexisting condition exclusions" regarding children under the age of 19; beginning in 2014, all preexisting condition exclusions are prohibited regardless of an individual's age.

- The term "preexisting condition exclusion" includes any limit or exclusion of benefits (including a denial of coverage) as a result of information relating to an individual's health status before the individual's obtains coverage (or, if coverage is denied, the date of coverage is denied).

- A plan or issuer may not rescind coverage with respect to an individual once the individual is covered under an applicable plan or coverage except in very limited instances regarding fraud or intentional misrepresentation of material fact. Additionally, the coverage may not be rescinded unless and until requisite notice is provided to the individual.

- An individual's inadvertent omission or unintended misrepresentation of a material fact does not give rise to a permissible rescission.

- If the Departments become aware of attempts to subvert the rules relating to the prohibition on rescission, additional guidance may be issued to ensure that individuals do not lose health coverage unjustly or without due process.

- The Interim Final Regulations also provide guidance regarding a host of patient protections regarding provider choice, pre-authorization, and cost-sharing with respect to emergency care services.

A more detailed summary and analysis of the Interim Final Regulations are set forth below. Please note that PPACA made parallel changes to the Public Health Service Act ("PHSA"), the Employee Retirement Income Security Act ("ERISA") and the Internal Revenue Code ("Code"). For purposes of this memorandum, all references are to the PHSA, but the summary and analysis also apply to ERISA and the Code.

PROHIBITION ON LIFETIME AND ANNUAL LIMITS

The Interim Final Regulations provide guidance regarding new PHSA section 2711, which generally prohibits plans and issuers offering group or individual health insurance coverage, from imposing annual or lifetime limits on the dollar value of "essential health benefits" for any individual.

No annual or lifetime dollar limits on "essential health benefits." The Interim Final Regulations provide that a plan or issuer generally must not establish any annual or lifetime limit

on the dollar amount of "essential health benefits" (as defined below) for any individual. The Interim Final Regulations provide that a plan or issuer may exclude all benefits for a condition; however, if any benefits are provided for a condition, then the prohibition regarding annual or lifetime limits applies.

> ***Comment:*** Based on the express statutory language and the Interim Final Regulations, it appears that the prohibition only applies to dollar limits on coverage. Thus, non-dollar limits, *e.g.*, a limit of 20 in-office doctor visits per year, would appear to be permitted.

Limits permitted on benefits that are not "essential health benefits." Under the Interim Final Regulations, a plan or issuer may impose annual or lifetime dollar limits with respect to any individual on benefits that are not "essential health benefits" (to the extent that such limits are permitted under other applicable federal or state law).

"Essential health benefits" has the same meaning as defined in PPACA section 1302(b) and applicable regulations. Regulations have yet to be issued, but PPACA section 1302(b) specifies that essential health benefits are (i) ambulatory patient services, (ii) emergency services, (iii) hospitalization, (iv) maternity and newborn care, (v) mental health and substance use disorder services, including behavioral health treatment, (vi) prescription drugs, (vii) rehabilitative and habilitative services and devices, (viii) laboratory services, (ix) preventive and wellness services and chronic disease management, and (x) pediatric services, including oral and vision care.

> ***Comment:*** The Interim Final Regulations impose a good faith requirement with respect to the interpretation of the term "essential health benefits" for plan/policy years beginning on or after September 23, 2010 but before the issuance of regulations defining the term. The guidance requires that any interpretation in accordance with the preceding sentence be used consistently.

Phase-in of prohibition on annual limits. Under the terms of the statute, a plan or issuer may have no annual limits with respect to essential health benefits during plan years beginning on or after January 1, 2014. The statute provides for a limited period of transition prior to January 1, 2014 during which a plan or issuer may impose "restricted" annual limits, which are defined in these Interim Final Regulations. Generally, it appears that the Departments have adopted a phased-in approach in moving plans/issuers to no annual limits come 2014. Under the approach set forth in the Interim Final Regulations, a plan or issuer is permitted to impose a maximum restricted annual limit as set forth below. Notably, only essential health benefits are taken into account in determining whether the limits are reached.

For Plan Years Beginning On or After…	But Before…	The Maximum Annual Restricted Limit Is…
September 23, 2010	September 23, 2011	$750,000
September 23, 2011	September 23, 2012	$1,250,000
September 23, 2012	January 1, 2014	$2,000,000

All grandfathered plans are subject to the prohibition on lifetime limits, and all grandfathered plans (except for grandfathered plans consisting of individual health insurance coverage) must adhere to the prohibition on annual limits.

The Secretary of HHS may waive the restricted annual limits for group health plans or health insurance coverage with an annual dollar limit below the restricted annual limits specified above. The Interim Final Regulations permit the HHS Secretary to waive restricted annual limits in certain circumstances. Under the terms of the Interim Final Regulations, the Secretary may waive the restricted annual limits if compliance with the restricted annual limits would otherwise result in a (i) significant decrease in access to benefits, or (ii) significant increase in premiums.

> ***Comment:*** It appears that traditional "mini-med" plans and stand-alone HRAs will need to seek a waiver from HHS to the extent they intend to continue to be viable. Notably, the waiver is not available for plan or policy years beginning after 2013. Thus, an open question remains as to the ongoing viability of "mini-med" plans and stand-alone HRAs.
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> ***Comment:*** The Interim Final Regulations regarding grandfathered plans issued last week include a series of rules that generally operate to preclude a grandfathered plan with annual limits from decreasing such limits, *i.e.*, making them tougher even if such decreased limit would otherwise fit within the restricted annual limits. The Interim Final Regulations released yesterday dovetail with last week's guidance and make clear that even though a grandfathered plan's annual limits may comply for purposes of the pre-2014 transition period, if a plan decreases those limits, *i.e.*, makes them tougher even if they still fall within the restricted annual limits, such plan will lose its grandfathered plan status.

Health FSAs are not subject to the prohibition on annual limits. Health flexible spending arrangements (as defined in section 106(c)(2)) ("health FSAs") are not subject to the prohibition on annual limits.

> ***Comment:*** In addition to not applying to health FSAs, the Interim Final Regulations make clear that restrictions on annual limits do not apply to Medical Savings Accounts ("MSAs") or Health Savings Accounts ("HSAs").

Integrated HRAs are permissible, but treatment of stand-alone HRAs remains unclear. The preamble to the Interim Final Regulations provides that where HRAs are integrated with a group health plan and the group health plan complies with the prohibition on annual and lifetime limits, the fact that the benefits under the HRA itself are limited does not violate PHSA section 2711 because the combined benefit satisfies the requirements. Nor do the restrictions on annual limits of PHSA section 2711 apply to stand-alone retiree-only HRAs. The treatment of stand-alone HRAs that are not retiree-only HRAs remains unclear. Significantly, the Departments have requested comments on how PHSA section 2711 should apply to stand-alone HRAs that are not retiree-only HRAs.

> ***Comment:*** As explained in the preamble to the Interim Final Regulations issued last week, retiree-only plans, including retiree-only HRAs, generally are not subject to the PPACA insurance reforms, including the prohibition on annual and lifetime limits.
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> Based on the express language of the Interim Final Regulations, it would appear that stand-alone HRAs with typical annual limits would not satisfy the prohibition on lifetime and annual limits. Unless and until guidance is issued providing express relief for stand-alone HRAs, plan sponsors would probably be wise to take a conservative view with respect to this issue.

Provides notice and special enrollment period for individuals who previously exhausted lifetime limit. With respect to individuals whose coverage or benefits ended because they reached a lifetime limit prior to the effective date of the Interim Final Regulations and who otherwise are eligible for such coverage or benefits on the first day of the first plan year beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans), transition relief is provided. The Interim Final Regulations provide for a special enrollment period during which such individuals can reenroll in available coverage.

Per the Interim Final Regulations, no later than the first day of the first plan year beginning on or after September 23, 2010, the plan or issuer must provide written notice to the individual (or to an employee for an employee's beneficiary) that the lifetime limit no longer applies and that such individual is again eligible for coverage or benefits. Such individual must be given a period of at least 30 days to enroll, and coverage must be effective no later than the first day of the first plan year beginning on or after September 23, 2010. The Interim Final Regulations provide that the requisite notice may be included with other enrollment materials if "prominent[ly]" displayed, and may be distributed to employees on behalf of the applicable individual.

If the individual is enrolling (or resuming active coverage) in a group health plan, he or she must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits, and must not be required to pay more than such similarly situated individuals.

> ***Comment:*** The notice requirements are very similar to the requirements that apply with respect to the adult child coverage mandate. For example, employees may be noticed on behalf of the beneficiary, and the notice may be included in other enrollment materials provided to employees. As noted above, if the notice is included as part of additional enrollment materials, such notice must be displayed in a "prominent" manner. It is unknown exactly what is meant by "prominent," as the term is undefined, but presumably the notice would need to be in a font size at least equal to the other enrollment materials and set off in some regard.
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> As with the adult child coverage mandate, there is a lack of clarity as to whether a plan or issuer must provide an independent election right to a beneficiary other than the employee (*e.g.*, a spouse or a child who would otherwise be eligible for coverage vis-à-vis the employee's election of employee-plus-one or family coverage), although a very reasonable interpretation is that no such independent right exists.

PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS

The Interim Final Regulations also provide guidance regarding new PHSA section 2704, which provides that a plan or issuer may not impose any preexisting condition exclusion with respect to such plan or coverage. Under the terms of the statute, the provision is generally effective for plan or policy years beginning on or after January 1, 2014. However, for plan years beginning on or between September 23, 2010 and December 31, 2013, a plan or issuer may not impose any preexisting condition exclusions with respect to enrollees who are under 19 years of age. Under the terms of the statute and the Interim Final Regulations, grandfathered group health plans and group insurance coverage must comply with the rules prohibiting preexisting condition exclusions, but grandfathered individual health insurance coverage is not required to comply.

Generally cannot impose any "preexisting condition exclusion." A plan or issuer may not impose any "preexisting condition exclusion." The term "preexisting condition exclusion" is defined in the Interim Final Regulations to mean a limit or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial), regardless of whether any medical advice, diagnosis, care, or treatment was recommended or received before that day.

The Interim Final Regulations make clear that the term "preexisting condition exclusion" includes any limit or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination, or a review of medical records relating to the pre-enrollment period.

> ***Comment:*** The preamble clarifies that the Interim Final Regulations do not modify the existing rule that an exclusion is not a preexisting condition exclusion if it applies regardless of when the covered individual's condition arose.

PROHIBITION ON RESCISSIONS

The Interim Final Regulations include guidance regarding new PHSA section 2712, which builds upon existing PHSA anti-rescission rules. Generally, new PHSA section 2712 provides that a plan or issuer may not rescind coverage with respect to an individual once the individual is covered under the applicable plan or coverage, except in very limited instances regarding fraud or intentional misrepresentation of material fact. Additionally, PHSA section 2712 provides that the plan or coverage may not be rescinded unless and until prior notice to the individual, as specified in the Interim Final Regulations. Please note that PHSA section 2712 and the related Interim Final Regulations apply to all grandfathered health plans.

Rescission only permitted in instances of fraud or intentional misrepresentation of material fact. A plan or issuer must not rescind coverage under a plan with respect to an individual (whether a single individual, individual within a family, or entire group of individuals) once the individual is covered under the plan or coverage involved, unless the individual (or a 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 the terms of the plan or coverage. The rule applies to both fully insured and self-insured plans.

Rescission not permitted where based on unintentional misrepresentation or omission of material fact. The preamble to the Interim Final Regulations makes clear that an individual's inadvertent omission or unintended misrepresentation of a material fact does not give rise to a permissible rescission. For example, where an individual unintentionally errs in completing an enrollment form and the plan or issuer later discovers the error, the individual's coverage cannot be retroactively rescinded.

> ***Comment:*** PHSA section 2712 essentially provides protection to individuals who may have done their best to complete complex enrollment questionnaires but may have made some errors for which the consequences were previously overly broad and unfair.

Rescission of group coverage where plan sponsor commits fraud. The Interim Final Regulations expressly provide that where a plan sponsor commits fraud, an employee's coverage may permissibly be rescinded.

> ***Comment:*** Although the Interim Final Regulations reference intentional misrepresentation by an individual as a basis for rescission, they do not reference the same with respect to plan sponsors; thus suggesting that a plan sponsor's intentional misrepresentation of a material fact is insufficient grounds for rescission of group coverage. Significantly, the preamble appears to indicate the contrary (*i.e.*, that intentional misrepresentation by a plan sponsor is grounds for rescission). Hopefully this will be clarified in future guidance.

If rescission permitted, 30 days' advance written notice required. In order to execute an otherwise permissible rescission, a plan or issuer must provide 30 days' advance written notice to affected participants.

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 toward the cost of coverage. Cancellations of coverage are addressed under other federal and state laws.

The Departments indicate willingness to issue future guidance if necessary to ensure spirit of statute is fulfilled. The preamble to the Interim Final Regulations makes clear that if the Departments become aware of attempts to subvert the rules relating to the prohibition on rescission, additional guidance may be issued to ensure that individuals do not lose health coverage unjustly or without due process.

PATIENT PROTECTIONS

PHSA section 2719A, as added by PPACA, sets forth three requirements relating to the choice of health care professionals and requirements relating to benefits for emergency services. The Interim Final Regulations provide guidance expanding upon these statutory requirements. Significantly, none of these requirements apply to grandfathered plans.

If plan requires or permits participant selection of primary care provider, must permit free choice from available options. The Interim Final Regulations provide that if a plan or issuer requires or permits an individual to designate a participating primary care provider ("PCP), then the plan or issuer must allow each individual to designate any participating PCP who is available.

Pediatrician may qualify as designated PCP. If a plan or issuer requires or provides for the designation of a participating PCP for a child, the plan or issuer must permit the designation of a physician who specializes in pediatrics as the child's PCP if the physician participates in the network of the plan or issuer and is available to accept the child.

OB/GYN also may qualify as PCP; prohibition on preauthorization requirement. If a plan or issuer provides coverage for obstetrical or gynecological ("OB/GYN") care and requires the designation of an in-network PCP, the plan or issuer may not require authorization or referral for a female participant, beneficiary, or enrollee who seeks OB/GYN care provided by an in-network health care professional (not necessarily a doctor) who specializes in OB/GYN.

Notice must be provided where designation of PCP is required or permitted. The Interim Final Regulations provide that if a plan or issuer permits or requires designation of a PCP, then notice must be provided to participants of their rights to (i) choose a PCP or pediatrician when a plan or issuer requires designation of a PCP, and (ii) obtain OB/GYN care without prior authorization. The Interim Final Regulations provide model notice language.

> ***Comment:*** The Interim Final Regulations make clear that unrestricted access to OB/GYN care does not preclude a plan from imposing rules and procedures with respect to the course of coverage following selection of the OB/GYN provider. Moreover, the Interim Final Regulations make clear that a plan or issuer may require the OB/GYN provider to notify the PCP or the plan or issuer of treatment decisions.

Prohibition on imposition of preauthorization requirement regarding emergency services. If a plan or coverage provides any benefits with respect to emergency services in a hospital, the plan or coverage must do so without the individual or the health care provider having to obtain prior authorization (even if the emergency services are out-of-network) and without regard to whether the provider furnishing the emergency services is an in-network provider.

Requirement that in-network cost-sharing applies for purposes of emergency services. Under the terms of the Interim Final Regulations, where a plan or coverage provides for out-of-network providers, a plan or issuer may not impose any administrative requirement or limit on benefits for out-of-network services that is more restrictive than the requirements or limits that apply to in-network emergency services.

Cost-sharing rules regarding out-of-network emergency services are limited. The Interim Final Regulations provide a complicated set of rules regarding the setting of cost-sharing for out-of-network emergency services. Generally, the rules seek to ensure that meaningful coverage is provided for emergency services before balanced billing begins.

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