

Interim Final Rule Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

Background

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA); a week later, he signed the Health Care and Education Reconciliation Act of 2010 (HCERA), which amended some portions of the PPACA. With that, the most comprehensive reform of the American health-care system in many years became law. This law will have a significant impact on employer-sponsored health care, including limits on preexisting condition exclusions, lifetime and annual limits, rescissions, as well as extending patient protections.

On June 28, 2010, the Departments of Labor, Treasury, and Health and Human Services issued an Interim Final Rule (IFR) outlining these restrictions on preexisting condition exclusions, lifetime and annual limits, and rescissions, along with the patient protections. These are outlined below.

Provisions

Preexisting Condition Exclusions

- A preexisting condition exclusion is defined as a limitation or exclusion of benefits 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.
 - Includes any limitations 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 effective date of coverage (or, if coverage was denied, the date of the denial), such as information provided on a pre-enrollment questionnaire, physical examination, or review of medical records relating to the pre-enrollment period.
- Terms relating to the preexisting condition exclusion:
 - In general, a group health plan may not impose any preexisting condition exclusion, as described above, for plan years beginning on or after January 1, 2014.
 - **The rules of this section DO apply to enrollees and applicants for enrollment who are under 19 years of age for plan years beginning on or after September 23, 2010, including grandfathered group health plans.**
- [Examples](#) can be found in the IFR.

No Lifetime or Annual Limits

- Group health plans or health insurers offering group health plans may not establish any lifetime or annual limits on the **dollar** amount of benefits for any individual.
 - Lifetime and annual limits exceptions – Group health plans may apply lifetime or annual limits to the dollar amount of coverage for an individual on specific covered benefits that are not essential health benefits, as long as they are otherwise permitted under applicable federal or state law.
 - Until regulations are issued further defining “essential health benefits,” the regulations refer to section 1302(b) of the PPACA and state that they will take into account “good faith efforts to comply with a reasonable interpretation of the term” essential health benefits. It goes on to clarify that a “reasonable interpretation” means the plan or issuer must apply the definition of essential health benefits consistently.
 - Annual limits only exception – Health Flexible Spending Accounts are exempt from the restriction on annual limits. The preamble to the regulations states that Medical Savings Accounts and Health Savings Accounts are also not subject to the annual limits restriction as they are generally not treated as group health plans since the funds can be used for both medical and non-medical expenses. Retiree-only Health Reimbursement Accounts (HRAs) are also not subject to this limitation. When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the annual limits restriction, the fact that benefits under the HRA by itself are limited does not violate these provisions because the combined benefit satisfies the requirements.
- The rules of this section do not prevent a group health plan from excluding all benefits for a condition.
 - However, if any benefits are provided for a condition, then the requirements of this section apply.

- Annual limits are allowed on a restricted basis (see schedule below) prior to January 1, 2014. Only essential health benefits can be included in the calculation of annual limits. Annual limits are allowed to be larger than the amounts listed below but cannot be lower:
 - For a plan year beginning on or after September 23, 2010, but before September 23, 2011, \$750,000.
 - For a plan year beginning on or after September 23, 2011, but before September 23, 2012, \$1,250,000.
 - For plan years beginning on or after September 23, 2012, but before January 1, 2014, \$2,000,000.
- This section applies to any individual whose coverage or benefits under a group health plan or issuer ended because they reached a lifetime limit on the dollar value of benefits OR who becomes or is required to become eligible for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010.
 - The plan or issuer is required to give individuals who have lost coverage by reason of reaching a lifetime limit on the dollar value of benefits written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits.
 - An employer must provide an enrollment period of at least 30 days (including written notice of the opportunity to enroll) to all individuals described above.
 - The opportunity to enroll must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010.
 - This notice may be provided to an employee on behalf of the employee's dependent.
 - This notice may be included with other enrollment materials that a plan distributes (e.g., during an annual open enrollment period) as long as this statement is prominent.
 - Coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.
 - The IFR provides [examples](#) relating to the coverage notice period.
- The provisions in this section are effective for plan years beginning on or after September 23, 2010.

Rescissions

- A rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect.
- A cancellation or discontinuation of coverage is not considered a rescission if:
 - The cancellation or discontinuation of coverage has only a prospective effect; OR
 - The cancellation or discontinuation of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.
- A group health plan must not rescind coverage under the plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage.
 - Coverage can be rescinded only if the individual (or a person seeking coverage on behalf of an individual) performs an act, practice or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.
- A group health plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded, regardless of whether the coverage is insured or self-insured or whether the rescission applies to an entire group or only to an individual within the group.
- [Examples](#) can be found in the IFR.

Patient Protections

- Designation of primary care physicians and access to obstetrical and gynecological care
 - Choice of health-care professional
 - If a group health plan requires or provides for beneficiaries to designate a participating primary care physician, then the plan or issuer must allow each beneficiary or participant to designate any primary care physician who is within the plan's network and available to accept the individual.
 - Designation of pediatrician as primary care provider
 - If a group health plan allows for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan issuer must permit the participant or beneficiary to designate a physician who specializes in pediatrics as the

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