New Regulations on Preexisting Condition Exclusions, Annual/Lifetime Value Limits and Rescissions

For more information regarding this or any other employment-related issue, please contact your Vorys attorney or a member of the Vorys Labor and Employment Group by calling 614.464.6400.

On June 22, 2010, the Departments of Health and Human Services, Labor and Treasury issued another installment of interim final regulations implementing the Patient Protection and Affordable Care Act (ACA). This installment of the interim final regulations addresses several mandates but fails to answer some key questions.

Preexisting Condition Exclusions (All plans): The prohibition on preexisting condition exclusions applies to children under 19 beginning with the first plan year starting after September 23, 2010, and to all individuals for plan years beginning on or after January 1, 2014. The regulations clarify that a plan may continue to exclude coverage of specific conditions, but that if coverage is provided for a condition, it must be covered without regard to prior diagnoses or treatment of that condition.

Retroactive Rescissions (All plans): Retroactive rescission of coverage is prohibited, with only the limited exception for rescissions due to fraud or an intentional misrepresentation of material facts. (Termination of coverage due to the failure to pay premiums is not a rescission and may be retroactive.) In the rare case that a plan/insurer can retroactively rescind coverage, the plan/insurer must provide at least 30 days advance notice of a rescission and allow an appeal of that conclusion. A plan/insurer is explicitly authorized to prospectively eliminate coverage for ineligible individuals.

As an example, the regulations explain that if an employee becomes ineligible for coverage due to a reduction in hours and the employer inadvertently fails to terminate the employee's coverage until sometime after he or she became ineligible, the employer cannot retroactively terminate coverage back to the date he or she became ineligible. However, the regulations do not address the common situations where coverage is provided to an ineligible individual due to an employee's action or inaction but where it would be difficult to prove fraud or intentional misrepresentation (e.g., where an employee enrolls an ineligible dependent or fails to provide prompt notice of a divorce). Further clarification would be helpful.

Lifetime Limits (All plans): Lifetime limits on the dollar value of "essential health benefits" for any individual participating in a group health plan are prohibited. However, in a crucial omission, the new regulations do not define "essential health benefits." Therefore, it is still not clear what types of embedded benefit lifetime limits will be affected. The implication is that we will not see a definition of "essential health benefits" in the near future. Good faith compliance with a reasonable interpretation of what is an essential health benefit will be allowed until regulations defining that term are issued.

Plans are required to provide notices to eligible individuals about the elimination of the lifetime limits and offer a special enrollment right to individuals who previously dropped coverage after reaching a lifetime limit.

Annual Dollar Value Limits (All plans): As with lifetime dollar value limits, the regulations do not define "essential health benefits." However, other aspects of this mandate were defined.

- The restriction on annual dollar value limits does not apply to health flexible spending arrangements (health FSAs), medical savings accounts (MSAs) or health savings accounts (HSAs).

- The annual dollar value limit restriction does not apply to health reimbursement arrangements (HRAs) that are integrated with a group health plan that meets the requirements under the ACA or to stand-alone retiree-only HRAs. (Comments were requested about the impact on stand-alone HRAs that cover active employees.)

- The entire exclusion of a benefit is not a prohibited annual or lifetime dollar value limit.

- The regulations allow annual per-individual dollar limits on "essential health benefits" during a three-year transition period:

For Plan Years starting:	Cannot have an annual limit lower than …
between 9/23/2010 – 9/22/2011	$750,000
between 9/23/2011 – 9/22/2012	$1,250,000
between 9/23/2012 – 12/31/2013	$2,000,000
after 12/31/2013	No annual limits permitted

  This is relevant to plans that had an annual or lifetime dollar limit on benefits in effect on March 23, 2010. If your plan had a lifetime dollar limit on March 23, 2010, you may convert the lifetime dollar limit to an annual dollar limit equal to the lesser of: (a) the former lifetime dollar limit; or (b) the amount listed above. If the employer's plan did not have a lifetime or annual dollar limit and such a limit is added, the plan will lose grandfathered status.

  The regulations do not define "dollar value" limit, leaving open the possibility that the government may yet treat day and visit limits as the functional equivalent of dollar limits. Guidance on this point would be helpful.

- Mini-Med plans may survive temporarily - HHS will create a waiver application process for plans/insurance with an annual dollar limit on benefits below the restricted annual limits permitted to seek a waiver to delay compliance with the rules on restricted annual limits if the plan/insurer can prove that raising the annual limits to comply with the minimum limits above would cause a significant loss of coverage or increase in premiums.

Expanded access under managed care plans (non-grandfathered plans only): If the plan requires designation of a primary care provider and the plan loses grandfathered status, the plan must include in your SPD a notice explaining that: (a) participants may designate any participating provider or pediatrician as their primary care provider; and (b) no authorization or referral is required for obstetrical or gynecological care from a participating provider. The regulation includes sample language for this notice.

Special Rules for Emergency Care (non-grandfathered plans only):

- A non-grandfathered plan/insurer cannot require prior authorization for emergency care, either in-network or out-of-network. However, a plan/insurer can still require notification within a specified period of time.

- A non-grandfathered plan/insurer cannot impose any administrative requirement or limitation on coverage provided by an out-of-network provider that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers.

- A non-grandfathered plan/insurer cannot charge higher cost-sharing amounts for out-of-network emergency care than for in-network emergency care. A plan/insurer meets this requirement if it reimburses out-of-network emergency care at the greater of three rates:

  1. the negotiated reimbursement rate for the median in-network provider, less any participant copayment or coinsurance that would be required for emergency care by an in-network provider;

  2. the rate that would have applied using the normal out-of-network process (usual, reasonable and customary), less any participant copayment or coinsurance that would be required for emergency care by an in-network provider; or

  3. the amount that would be paid under Medicare Part A or B, less any in-network copayment or coinsurance.

     For example, a plan reimburses in-network care at 80% of negotiated rates and out-of-network care at 50% of usual, reasonable and customary charges. A participant receives care for which the negotiated rate for the 4 in-network providers would have been $85, $100, $120 or $130. The out-of-network provider charged $125, the UCR for the services was $116 and the Medicare rate would have been $80. The plan satisfies this requirement if it pays the greatest of: (1) $92, 80% of the median in-network provider's rate; (2) $92.80, 80% of the UCR amount; or (3) $80, the Medicare rate. The patient would be obligated to pay the out-of-network provider the remaining balance of $32.20.

- If the plan has a general deductible for out-of-network care, the plan may, but is not required to, subject out-of-network emergency care to that deductible.

- If the plan has an out-of-network, out-of-pocket maximum, the plan must count any out-of-network emergency care against that limit, and cover any charges after the out-of-pocket maximum has been met.

- Out-of-network emergency care providers may balance bill participants to the extent permitted by state law.

The interim final regulations will be published in the Federal Register on June 28 and are effective August 27, 2010.

Do you have employees living in Oklahoma? If so, check with your third-party administrator or insurer. Beginning in August 2010, a new Oklahoma law imposes a 1% fee on all medical claims paid for residents of Oklahoma.
