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Legal Advice for Health Plans

HEALTH LAW ALERT
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Affordable Care Act Rules Issued for Preexisting Conditions, Lifetime & Annual Limits, Rescissions, and Patient Protections

Pre-ex, Rescissions Provisions Expand Coverage at Plans' Expense

Today, the Federal agencies responsible for implementing the Patient Protection and Affordable Care Act (the "Affordable Care Act")[1] issued interim final rules addressing several of the health reform provisions enacted earlier this year. The Rules, published at 75 *Federal Register* 37187, address health plan obligations with respect to preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protections. Health plans—including grandfathered health plans—will be affected by many of these requirements for plan years beginning on or after September 23, 2010 (the "Rules' Effective Date").

In the Rules, the Federal agencies interpret two provisions of the Affordable Care Act broadly to expand coverage at the expense of health plans beginning on the Rules' Effective Date. First, the Affordable Care Act prevents health plans (other than individual grandfathered plans) from imposing a preexisting condition exclusion on individuals 18 and under beginning on the Effective Date (and on anyone for plan years beginning on or after January 1, 2014). The Rules interpreting this provision prohibit plans from denying enrollment to individuals due to a preexisting condition. That means, beginning on the Rules' Effective Date, an insurer offering individual coverage (in a non-grandfathered plan), for example, cannot deny coverage to a family because of a minor's preexisting condition. Second, the rescission requirements prohibit an insurer from retroactively terminating group coverage to an individual who, due to the plan sponsor's error, remains enrolled after losing eligibility (though the insurer may terminate coverage prospectively upon learning of the error). The insurer would therefore be liable for the individual's claims, notwithstanding that the individual was not eligible under the terms of the group health plan.

The Rules are codified at 45 C.F.R. Parts 144, 146, and 147 (Office of Consumer Information and Insurance Oversight), 29 C.F.R. Part 2590 (Employee Benefits Security Administration), and 26 C.F.R. Parts 54 and 602 (Internal Revenue Service). The Office of Consumer Information and Insurance Oversight version of the Rules is incorporated into my compilation of Selected Federal Health Insurance Provisions, which is available here (or go to the "Resources" page of tbixbylaw.com.) See the first line under "Compiled Rules."

[1] The Federal Agencies are the Department of Health and Human Services' Office of Consumer Information and Insurance Oversight, the Department of Labor's Employee Benefits Security Administration, and the Department of Treasury's Internal Revenue Service.

Preexisting Condition Exclusions

The Agencies explain that the Affordable Care Act and the Rules prohibit "not just an exclusion of specific benefits associated with a preexisting condition . . . but a complete exclusion from such plan or coverage, if that exclusion is based on a preexisting condition." This interpretation means that a preexisting condition cannot be used as the basis for denying an individual coverage in the group or individual market.

Although the prohibition on preexisting condition exclusions does not generally go into effect until January 1, 2014, the Affordable Care Act creates an exception for enrollees under the age of 19. Under this exception, the preexisting condition exclusion prohibition goes into effect for individuals 18 and younger on the Rules' Effective Date—the first plan year beginning on or after September 23, 2010. Only individual grandfathered plans are exempted from the requirement. Accordingly, health plans (other than individual grandfathered plans) will not be allowed to deny coverage to individuals under age 19 due to a preexisting condition.

Rescissions

The Rules define rescission as "a cancellation or discontinuance of coverage that has retroactive effect" and, in accordance with the Affordable Care Act, prohibit health plans from rescinding coverage, except in the case of fraud or intentional misrepresentation of material fact. The Agencies impose an "advance notice" requirement, so that health plans must give policyholders (in the case of an individual policy) and participants (in the case of group coverage) written notice of the rescission 30-days prior to the rescission being effective. The advance notice "will provide individuals and plan sponsors with an opportunity to explore their rights to contest the rescission." Nevertheless, to the extent permitted by applicable law, a health plan may "void coverage retroactively."

The Agencies emphasize that the fraud or material misrepresentation on which any rescission is based must be made by the individual him/herself or a person seeking coverage on behalf of the individual. To illustrate the rescission provisions, the Rules give an example of an employee who ceases to be eligible for group plan coverage, but "the plan mistakenly continues to provide health coverage" to the employee. The example concludes that, because neither the employee nor the employer (on the employee's behalf) committed fraud or made an intentional misrepresentation of material fact, the plan cannot rescind coverage. Health insurers should consider how this application of the Affordable Care Act's rescission provision will affect their relationship with employer groups that neglect to timely update enrollment records.

Lifetime and Annual Limits

The Rules prohibit lifetime limits on the dollar amount of "essential health benefits." The prohibition applies to all plans, including grandfathered individual and group plans. Annual limits on the dollar amount of essential health benefits are also prohibited for plan

years beginning on or after January 1, 2014. Moreover, annual limits are restricted for plan years beginning on or after September 23, 2010. Annual limits on the dollar amount of essential health benefits cannot be less than:

- $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 on or after September 23, 2012, but before January 1, 2014.

The restrictions on annual limits apply to all plans except for grandfathered individual plans. Grandfathered group plans must, therefore, comply with the annual as well as lifetime restrictions beginning on the Rules' Effective Date.

Although the Agencies have not yet defined the term "essential health benefits," under the Affordable Care Act, the term includes at least:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services;
- Chronic disease management; and
- Pediatric services, including oral and vision care.

Because the Agencies have not yet defined the term "essential health benefits," they "will take into account good faith efforts to comply with a reasonable interpretation of the term."

The restrictions on annual limits do not apply to health flexible spending arrangements (FSAs). Nor do the annual limit restrictions apply to a Health Reimbursement Arrangement (HRA), provided that the HRA is integrated with other group health plan coverage that complies with the annual limit restrictions. The Agencies request public comment on the status of stand-alone HRAs, however.

Patient Protections

The Rules address two Affordable Care Act "patient protection" provisions. In doing so, the Agencies establish a formula for reimbursing non-participating hospitals for emergency services and require notices for new patient rights. Neither of the provisions applies to grandfathered plans (group or individual).

Emergency Services. The Affordable Care Act requires health plans that cover emergency services to cover them at non-participating hospitals without prior authorization or other restrictions and at the same copayment amount or coinsurance rate that would apply for participating providers. An enrollee may, however, be responsible for any additional expense incurred resulting from choosing a hospital with which the health plan has not negotiated a discount—the enrollee is subject to the emergency service provider's balance billing. In order to "avoid the circumvention of [the Affordable Care Act's] protections," the Rules require health plans to pay "a reasonable amount . . . before a patient becomes responsible for a balance billing amount." The Rules establish a three-prong test for determining this reasonable amount. A health plan must pay (after reducing the amount for applicable copayment or coinsurance) the greatest of (a) the median[2] in-network provider-negotiated rate, (b) 100% of the usual and customary fee (or other method the plan generally uses to calculate out-of-network fees), and (c) the amount Medicare would pay.

Choice of Health Care Professional. The Affordable Care Act requires health plans that (a) have provider networks and (b) require enrollees to designate a primary care professional to allow the enrollee to designate any participating primary care provider who is accepting patients. Enrollees may choose an available participating pediatrician to be the primary care provider for an enrolled child. A plan is prohibited from requiring an authorization or referral for covered obstetrical or gynecological care. The Rules require health plans to provide notice to plan participants (or individual policyholders) of these requirements whenever the plan provides a description of benefits. The Rules provide a model notice to meet these notice requirements.

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[2] The "median" reimbursement is different from the "average" (or "mean") reimbursement. Half of the rates a health plan negotiates with network providers would be greater than the median reimbursement and half would be less than the median.