

Administration Issues Regulation on Pre-existing Condition Exclusion, Lifetime and Annual Dollar Limits, Rescissions, and Patient Protections

Issue: Health Insurance Reform

Date: June 23, 2010

Action Taken: On June 22, the U.S. Departments of Health and Human Services (HHS), Labor, and Treasury issued interim final regulations implementing the rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Patient Protection and Affordable Care Act regarding pre-existing condition exclusions, lifetime and annual dollar limits on benefits, rescissions, and patient protections.

NAIFA Position: In order to assist clients comply with the new market reforms, NAIFA members need to understand the new restrictions and their application to grandfathered plans. The following Q&A will help members and their clients comply with the new restrictions.

Pre-existing Condition Exclusions

Q: Are pre-existing condition exclusions prohibited?

A: Yes. The new law prohibits any pre-existing condition exclusion from being imposed by group health insurance and extends this prohibition to individual health insurance coverage.

Q: When does the pre-existing condition prohibition go into effect?

A: The prohibition is generally effective to plan years (in the individual market, policy years) beginning on or after January 1, 2014. However, for enrollees who are under 19 years of age, this prohibition becomes effective for plan/policy years beginning on or after September 23, 2010.

Q: Do grandfathered plans have to comply with the new pre-existing condition prohibition?

A: A grandfathered health plan that is a group health plan or group health insurance coverage must comply with the prohibition against pre-existing condition exclusions. However, a grandfathered health plan that is individual health insurance coverage is not required to comply.

Annual and Lifetime Dollar Limits

Q: Are there annual and lifetime benefit limit restrictions?

A: The new law restricts annual and lifetime limits on the dollar value of health benefits for plan years beginning on or after September 23, 2010, and prohibits them starting in 2014.

Q: Do the annual and lifetime benefit limit restrictions apply to grandfathered plans?

A: They do apply to grandfathered group plans. Grandfathered individual market policies are exempted from the provision.

Q: Does the restriction on annual limits apply to health flexible spending arrangements (FSAs)?

A: The annual limit rules do not apply to health FSAs. FSAs are specifically limited to \$2,500 (indexed for inflation) per year beginning with taxable years in 2013.

Q: Does the restriction on annual limits apply to Medical Savings Accounts (MSAs) or Health Savings Accounts (HSAs)?

A: The annual limit rules do not apply to MSAs or HSAs. Both MSAs and HSAs generally are not treated as group health plans because the amounts available under the plans are available for both medical and non-medical expenses. And, annual contributions to these accounts are subject to specific statutory provisions that require that the contributions be limited.

Q: Does the restriction on annual limits apply to health reimbursement arrangements (HRAs)?

A: When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements, the fact that benefits under the HRA by itself are limited does not violate the restriction on annual limits because the combined benefit satisfies the requirement.

Q: Do these dollar limit restrictions prohibit plans from excluding all benefits for a condition?

A: No, but if any benefits are provided for a condition, then the requirements of the rule apply. An exclusion of all benefits for a condition is not considered to be an annual or lifetime limit.

Q: May plans beginning before January 1, 2014 establish “restricted annual limits” on the dollar value of essential health benefits?

A: Yes. A transition approach may be adopted as follows:

- For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000
- For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1.2 million
- For plan or policy years beginning on or after September 23, 2012 but before September 23, 2014, \$2 million

Q: What are essential health benefits?

A: The regulations defining essential benefits have not yet been issued. See [FAQ #28](#).

Q: May a plan or issuer impose annual or lifetime per-individual dollar limits on non-essential benefits?

A: Yes. A plan or issuer may impose annual or lifetime per-individual dollar limits on specific covered benefits.

Q: Are there special allowances for limited-benefit medical plans (mini-med plans)?

A: Yes. The secretary of Health and Human Services is to establish a program under which the requirements relating to restricted annual limits may be waived if compliance with these interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Limited-benefit plan guidance is expected in the near future.

Q: What type of notice is required regarding changes to dollar limits?

A: Group health plan or insurers that offer group health coverage must provide written notice to plan participants that the plan's lifetime dollar limits no longer apply. Participants must be given 30 days or more to enroll to receive coverage that employers would have to offer by the first day of the plan year beginning on or after September 23, 2010, which for calendar year plans would be January 1, 2011.

Rescissions

Q: When are plans prohibited from rescinding policies?

A: Group health plans and individual health policy rescissions are prohibited, except in cases involving fraud or intentional misrepresentation of a material fact, effective for plan years beginning on or after September 23, 2010.

Q: What is a rescission?

A rescission is a cancellation or discontinuance of coverage that is retroactive.

Q: Is non-payment a rescission?

A: A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect; or if effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. While non-payment is not a rescission, it is an allowable reason for retroactive cancellation.

Q: What type of rescission notice is required?

In situations in which rescission would be allowed, group health plans or insurers would have to notify participants 30 days in advance.

Q: Are grandfathered plans prohibited from rescinding policies?

A: The rules regarding rescissions and advance notice apply to all grandfathered health plans, effective for plan years beginning on or after September 23, 2010.

Patient Protections

Q: Are there additional patient protections regarding primary care?

A: Yes.

- Any participating primary care provider who is available to accept the participant or beneficiary can be designated as the primary care provider.
- Any participating physician who specializes in pediatrics can be designated as the primary care provider.
- The plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

Q: What notice is required if a plan requires the designation of a primary care provider?

A: If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of their rights to choose a any participating primary care provider or pediatrician and no authorization or referral is needed for obstetrical or gynecological care.

Model Language

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or

procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

Q: What are the new emergency services benefits required for group plans?

A: If a group health plan, or a health insurance issuer offering group health insurance coverage, provides any emergency room benefits, the plan or issuer must provide coverage for emergency services in the following manner:

- Without prior authorization determination, even if the emergency services are provided on an out-of-network basis
- Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services
- If the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers
- If the emergency services are provided out-of-network, by complying with the cost sharing requirements
- Without regard to any other term or condition of the coverage, other than:
 - The exclusion of or coordination of benefits;
 - An affiliation or waiting period permitted
 - Applicable cost sharing.

Q: How are cost-sharing requirements for emergency services determined?

A: Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirement imposed if the services were provided in-network. However, an enrollee may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan is required to pay.

A group health plan complies with the requirements if it provides benefits with respect to an emergency service in an amount equal to the greatest of the three amounts:

- The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. If there is more than one amount negotiated with in-network providers for the emergency service, the amount is the median of these amounts, excluding any in-network copayment or coinsurance imposed. In determining the median, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount is disregarded.
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed. The amount is determined without reduction for out-of-

network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services. For example, if a plan generally pays 70 percent of the usual, customary, and reasonable amount for out-of-network services, the amount for an emergency service is the total (that is, 100 percent) of the usual, customary, and reasonable amount for the service, not reduced by the 30 percent coinsurance that would generally apply to out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).

- The amount that would be paid under Medicare (part A or part B) for the emergency service, excluding any in-network copayment or coinsurance imposed.

Q: Are grandfathered plans exempt from the new emergency services rules?

A: These rules regarding emergency services do not apply to grandfathered health plans.

Additional questions are answered in NAIFA's [FAQ](#) on the new law and quick look at the implementation of various provisions can be found in the [timeline](#).

Next Steps: The Departments invite comments from the public. Written or electronic comments and requests for a public hearing must be sent by September 27, 2010.