



Employee Benefits Law Action Memo

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Electronic Dispatch

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PREEXISTING CONDITION, LIFETIME AND ANNUAL LIMIT, AND OTHER HEALTH PLAN RULES RECENTLY ISSUED

Pursuant to the Patient Protection and Affordable Care Act (“PPACA”), the Internal Revenue Service, the Department of Labor (“DOL”), and the Department of Health and Human Services (collectively, “the agencies”) recently issued interim final rules for health plans and insurance issuers relating to (1) preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protections; and (2) claims, appeals, and review procedures.

Preexisting Condition Exclusions. Under the new rules, no group plan or issuer (except grandfathered plans that are individual insurance coverage) may impose a preexisting condition exclusion (including any exclusionary waiting period) *for any enrollee under age 19* in plan years beginning on or after September 23, 2010, and *any enrollee* (regardless of age) in plan years beginning on or after January 1, 2014. The definition of “preexisting condition” includes any *denial of coverage* based on a preexisting condition (i.e., not just benefits related to the condition). As of the applicable effective date, plans and issuers must provide coverage on a prospective basis for individuals denied coverage based on a preexisting condition, and for benefits related to preexisting conditions that are currently excluded under a health plan. The rules also prohibit any limitation or exclusion based on information related to an individual’s health status (e.g., such as a condition identified as result of a pre-enrollment questionnaire or physical examination).

Lifetime and Annual Limits. Effective for plan years beginning on or after September 23, 2010, all group plans and issuers (with the exception of certain account-based health plans and grandfathered plans that are individual insurance coverage) are prohibited from imposing lifetime or annual limits on the dollar value of “essential health benefits” (including at a minimum those benefits listed in PPACA Section 1302(b)).¹ Until further guidance is issued, the agencies will take into account the consistent application of good faith reasonable interpretations of the term “essential health benefits” as applicable to the lifetime and annual limit prohibitions.

In an effort to provide transitional relief, the rules do permit plans and issuers to impose the following “restricted annual limits” (“RALs”) in plan years beginning before January 1, 2014:

For plan years beginning on or after --	Restricted Annual Limit
September 23, 2010 but before September 23, 2011	\$ 750,000
September 23, 2011 but before September 23, 2012	\$ 1.25 million
September 23, 2012 but before January 1, 2014	\$ 2 million

The rules clarify that the RALs are minimums for plan years beginning before January 1, 2014, i.e., plans or issuers may impose higher limits or no limits. Generally, grandfathered plans that impose new limits or reduce the amount of an annual limit (in existence as of March 23, 2010) will lose grandfather status. Note, a grandfathered plan with an existing lifetime limit (as of March 23, 2010) and no existing annual limit, may impose a new annual limit (subject to the applicable RAL minimum) and retain grandfather status by eliminating the existing lifetime limit.

Certain limited benefit plans or policies (i.e., “mini-meds”) may be eligible for a waiver program, in cases where annual dollar limits fall below the RAL minimums, and compliance would result in a significant decrease in access to benefits or a significant increase in premiums for enrollees or policyholders. HHS Guidance on the waiver application process is expected to be issued in the near future.

Lifetime Limit Notice. Individuals who have lost coverage because of reaching lifetime limits, and who would otherwise be eligible for coverage, must be given notice that the lifetime limit no longer applies. If such individual is no longer enrolled in the plan or policy, he or she must be given notice of the opportunity to enroll (during a special 30-day enrollment period) no later than the first day of the first plan year beginning on or after September 23, 2010. Model language is available at <http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc>.

Rescissions. Effective for plan years beginning on or after September 23, 2010, all group plans are prohibited from rescinding coverage except in the case of fraud or an intentional misrepresentation of material fact. If such rescission is permitted, plans and issuers must provide participants with 30 days notice prior to the date coverage is rescinded. The term “rescission” means any cancellation or discontinuance of coverage that has retroactive effect. Note, retroactive cancellation of coverage due to nonpayment of premiums or contributions does not constitute a “rescission” under the rules.

Patient Protections. For plan years beginning on or after September 23, 2010, all new group plans and issuers that use provider networks must comply with the following rules relating to patient protections:

Choice of Health Care Provider. If an enrollee is required to designate a primary care provider (“PCP”) under a plan or policy: (i) the plan or issuer must permit the enrollee to designate any PCP who is available to accept the enrollee; (ii) the plan or issuer must permit a child-enrollee to designate an in-network pediatrician as his or her PCP (if available to accept the child); and (iii) if a plan or issuer covers obstetrics/gynecological care, the plan or issuer must not require preauthorization before an enrollee seeks services from an in-network OB/GYN provider. Notice of changes required by the choice of provider rules must be provided when the plan or issuer provides an enrollee with an SPD or other summary of benefits. Model language is available at <http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc>.

Coverage of Emergency Services. If a plan or issuer covers emergency care in a hospital, the plan or issuer may not require prior authorization for services even if the health care provider is out of network. In addition, plans must not impose coinsurance rates or copayments for out of network emergency services in excess of the amounts that would have otherwise been required for services provided in network. Out of network providers, however, may bill participants for any remaining balance after the plan or policy pays, provided the plan or policy complies with certain cost-sharing requirements.

Claims, Appeals and Review Procedures. For plan years beginning on or after September 23, 2010, all new plans and issuers must comply with the new rules related to internal claims and appeals and external reviews of adverse benefit determinations, including rescissions of coverage. These new procedural requirements add to the existing claims and appeals procedures currently required under ERISA, and requires that plans or issuers: (1) notify claimants as soon as possible, but no later than 24 hours after receipt of an urgent care claim; (2) provide claimants with any new or additional evidence that arises in connection with the claim; (3) ensure that claims are processed in a manner that avoids any conflict of interest; (4) ensure notices are culturally and linguistically appropriate, and contain certain required information; (5) strictly adhere to the required internal claims and appeals procedural requirements; and (6) continue to provide coverage pending the outcome of an internal appeal. A claimant is deemed to have exhausted administrative remedies if a plan or issuer fails (even if the failure is de minimis) to strictly adhere to the new internal claims and appeals procedural rules, and may immediately pursue external review. All new plans and issuers (applies only to the insurance issuer for insured plans) must comply with either a state or the Federal external review process, whichever is applicable under the rules. In certain cases, claimants may be permitted to simultaneously proceed with both the internal appeals process and expedited external review.

New individual health insurance issuers are subject to all the internal claims and appeals rules that apply to group plans and issuers, and must adhere to three additional standards: (1) decisions on initial eligibility are subject to internal claims and appeals procedures; (2) only one level of review is permitted for determinations of individual health coverage; and (3) all claims and notice records must be maintained and made available upon request for at least 6 years.

Most of the rules discussed in this memorandum are effective for plan years beginning on or after September 23, 2010. Employers that maintain group health plans, and insurers that maintain group or individual policies, should evaluate and determine the extent to which current plan or policy provisions may need to be updated to comply with the new rules by the applicable effective date.

If you have any questions about this memorandum, please contact Susie Dahline in our Syracuse office (315-218-8227, sdahline@bsk.com) or any of the other members of our Employee Benefits and Executive Compensation Practice Group listed below.

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