Benefits Alert

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The Patient Protection and Affordable Care Act: Regulations and Model Notices Regarding Mandated Health Plan Provisions

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The Department of Treasury, Department of Labor ("DOL"), and Department of Health and Human Services ("HHS") have recently issued interim final regulations providing guidance on certain mandated health plan provisions. The regulations generally apply to group health plans and insurers for plan years beginning on or after September 23, 2010 (that is, January 1, 2011 for calendar-year plans). Employers need to evaluate the new guidance to determine how it might affect their plan designs. The DOL has also recently issued model notices regarding the extension of dependent care coverage to age 26, the prohibition in lifetime limits, and certain patient protections. These notices as well as the regulations can be found on the DOL website at the following link: http://www.dol.gov/ebsa/healthreform/index.html.

Preexisting Condition Exclusions

The Act prohibits preexisting condition exclusions for plan years beginning on or after January 1, 2014. However, for enrollees who are under age 19, the effective date is plan years beginning on or after September 23, 2010. The regulations revise the definition of preexisting condition to include a denial of coverage. Furthermore, the preamble provides that, for enrollees under 19, this prohibition includes both denial of enrollment as well as denial of specific benefits based on a preexisting condition.

Lifetime and Annual Limits

Lifetime limits on "essential health benefits" are prohibited under the Act. Annual limits on such benefits are initially restricted and ultimately prohibited. The regulations clarify that an exclusion of *all* benefits for a specific condition is not considered to be a lifetime or annual dollar limit. However, if *any* benefits are provided for a condition, then the restrictions apply.

These restrictions only apply to "essential health benefits." The regulations only define "essential health benefits" by reference to the broad provision in the Act, which includes the following:

- 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 and chronic disease management
- Pediatric services, including oral and vision care

For purposes of enforcement, until further regulations are issued, the agencies will take into account good-faith efforts to comply with a reasonable interpretation of this term.

Furthermore, for plan years beginning before January 1, 2014, the regulations permit "restricted annual limits" with respect to essential health benefits under a three-year phased approach. The restricted annual limits may be no less than the following:

- $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;

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- $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and
- $2 million for plan years beginning on or after September 23, 2012, but before January 1, 2014.

These restricted annual limits apply on an individual basis (that is, any overall annual dollar limit applied to families may not operate to deny a covered individual benefits for the plan year). The regulations also allow HHS to establish a waiver program; however, at this point, no guidelines have been issued.

The restriction on annual limits applies differently to account-based plans, especially where other rules apply to limit the benefits available. Since health care flexible spending accounts will be subject to an annual limit of $2,500 (indexed for inflation), beginning in 2013, the annual limit restrictions are inapplicable to such plans. These restrictions also do not apply to health savings accounts. Health reimbursement arrangements ("HRAs") that are integrated with other coverage (as part of a larger group health plan) are not subject to the annual limit restrictions, so long as the other coverage complies with lifetime and annual limit requirements. However, a stand-alone HRA (other than a retiree-only HRA) could potentially be subject to the restrictions.

For those participants who reach a lifetime limit before the restrictions became effective and remain eligible to participate in the plan, such participants must be given a written notice that such limit no longer applies. If the participants are no longer enrolled, they must be provided with a written notice (no later than the first day of the first plan year beginning on or after September 23, 2010) informing them of an enrollment opportunity that must continue for at least 30 days. The regulations provide details and examples regarding this rule, and the DOL has issued a model notice.

Prohibition on Rescission

Group health plans and insurers may no longer rescind coverage except in the case of fraud or intentional misrepresentation of a material fact, provided such restriction is contained in the plan or policy. The regulations require that at least 30 calendar days' advance notice be provided to an individual *before* coverage may be rescinded. The regulations define rescission as a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuation of coverage that is prospective only, or one that is effective retroactively but is attributable to nonpayment of premiums or contributions, is not a rescission.

Patient Protections

The regulations provide guidance on the provisions of the Act relating to choice of health care professionals. If a health plan or insurer requires a participant to designate a participating primary care provider from a network, it must permit the designation of *any* participating primary care provider who is available to accept the participant. Similarly, if the plan or insurer requires the designation of a pediatrician, it is required to permit the designation of *any* available pediatrician within the network as the primary care provider. Plans or insurers that require designation of an in-network primary care provider may not require authorization or referral for a female participant who seeks covered obstetrical or gynecological care provided by an in-network health care professional who specializes in this field (including to non-physicians). Plans and insurers are required to provide notice to participants of these rights when applicable; the regulations contain model language and timing rules relating to this notice, and the DOL has issued a model notice.

The new regulations also provide guidance on the provisions of the Act relating to coverage of emergency services. If a covered plan provides for benefits with respect to services in an emergency department of a hospital, the plan must cover such services:

- without the need for prior authorization, even if out-of-network;
- without regard to whether the health care provider 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 of the Act; and
- without regard to any other term or condition of the coverage, other than certain terms such a coordination of benefits provision.

More About Grandfathered Plans

The patient protection provisions of the Act generally do not apply to health plans maintained as grandfathered plans. The regulations, however, reiterate that the requirements of the Act relating to preexisting condition exclusions, lifetime and annual limits, and rescissions apply to grandfathered plans.

If you have any questions about the Act, please contact one of the attorneys in the Employee Benefits & Executive Compensation Group at Bradley Arant Boult Cummings LLP.