Summary of Interim Final Rule on Requirements Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections
August 9, 2010

The Departments of Health and Human Services, Labor, and Treasury published an interim final rule in the June 28 Federal Register to implement provisions of the Patient Protection and Affordable Care Act (PPACA) related to patient protections for individuals enrolled in private health insurance plans. Those protections include prohibitions on pre-existing condition exclusions, lifetime and annual limits on the dollar value of coverage, and coverage rescissions, as well as a so-called Patient’ Bill of Rights that includes choice of provider provisions. Comments on the interim final rule will be accepted until Aug. 27.

The new requirements apply to group and individual health plans, though some of the requirements do not apply to plans with grandfathered status. The term group health plan, as used in the regulation, includes insured and self-insured group health plans.

Prohibition of Pre-existing Condition Exclusions

The regulation prohibits plans from denying coverage to individuals on the basis of a pre-existing medical condition. The prohibition goes into effect in the first plan or policy year beginning after Sept. 23, 2010, for individuals under age 19, and after Jan. 1, 2014, for those over age 19.

A pre-existing condition exclusion is defined as limiting or excluding benefits for a condition based on the fact that the condition existed before the effective date of coverage. A plan that covers services for heart disease but does not cover the same services for congenital heart disease would be in violation. However it would not be considered a pre-existing condition if a plan does not cover services for any other heart disease, including congenital heart disease.

Grandfathered group health plans and group health insurance coverage must comply with the pre-existing condition provisions, but grandfathered individual health insurance coverage is not required to comply.

Restrictions on Lifetime and Annual Limits

*Lifetime limits:* The regulation prohibits lifetime limits on the dollar value of coverage for essential health benefits. Those whose coverage or benefits ended before the implementation of the lifetime limit prohibition must be provided with notice that the lifetime limit no longer applies, and must be given an opportunity to re-enroll if they are no longer covered. The notice and opportunity to re-enroll must be provided by no later than the first day of the first new plan
year that begins after Sept. 23, 2010.

Annual limits: The regulation generally prohibits annual limits on the dollar value of coverage for essential health benefits. However, plans will be able to impose “restricted annual limits” on essential health benefits prior to Jan 1, 2014. The restricted annual limits apply on an individual basis and are phased out over a three-year period, as follows:

- For policy years beginning between Sept. 23, 2010, and Sept. 23, 2011, annual limits for essential health benefits may not be less than $750,000
- For policy years beginning between Sept. 23, 2011, and Sept. 23, 2012, annual limits for essential health benefits may not be less than $1.25 million
- For policy years beginning between Sept. 23, 2012, and Dec. 31, 2013, annual limits for essential health benefits may not be less than $2 million
- For policy years beginning Jan. 1, 2014, plans may not impose an annual limit on essential health benefits

A plan or issuer may continue to impose annual or lifetime per-individual dollar limits on specific covered non-essential health benefits.

The Secretary of HHS must define the essential health benefit package in regulation. In the meantime, the Departments will take into account good faith efforts to comply with a reasonable interpretation of essential health benefits. The definition used must be applied consistently to a benefit by a plan or insurer. For example, a plan could not impose a lifetime limit on a specific benefit, thus declaring it a non-essential benefit, then also treat that benefit as an essential health benefit in order to impose a restricted annual limit.

An exclusion of all benefits for a condition is not considered to be an annual or lifetime dollar limit; however, if an insurer or plan provides benefits for a condition the requirements apply.

Application to grandfathered plans: For grandfathered plans:

- The prohibition on lifetime limits applies to plan years after Sept. 23, 2010
- The prohibition on annual limits, including the restricted annual limit prior to Jan. 1, 2014, apply to grandfathered group health plans but not grandfathered individual health insurance coverage
- If a grandfathered plan that did not impose an annual or lifetime limit on the dollar value of all benefits as of March 23, 2010, imposes an overall annual limit, it will cease to be a grandfathered plan
- If a grandfathered plan that imposed an overall lifetime limit but no overall annual limit on the dollar value of all benefits as of March 23, 2010, imposes an annual limit that is less than the lifetime limit, it will cease to be a grandfathered plan
• If a grandfathered plan that imposed an overall annual limit on the dollar value of all benefits as of March 23, 2010, decreases the dollar value of the annual limit, it will cease to be a grandfathered plan

**Prohibition on Rescissions**

A group health plan or a health insurance issuer that offers group or individual health insurance coverage may not rescind coverage except in the case of fraud or an intentional misrepresentation of material fact. Insurers must provide at least 30 days notice to an individual before rescinding coverage for one of the limited allowable purposes.

The regulation defines rescission as a cancellation or discontinuance of coverage that has retroactive effect. It is not considered to be a rescission if cancellation has a prospective effect, or is retroactive but attributable to failure to pay premiums or other contributions toward the cost of coverage. The provision does not pre-empt state laws that are more protective of individuals than federal law.

The rules regarding rescissions apply to all grandfathered plans.

**Patient Protections**

*Choice of health care provider:* The regulation imposes three requirements relating to the choice of a health care professional. These requirements apply only to providers with whom the plan has a contractual or negotiated relationship. The requirements do not apply to grandfathered plans.

• If a plan requires that an enrollee designate a participating primary care provider, the plan must permit each enrollee to designate any participating primary care provider who is available to accept him. The plan must give notice to the enrollee of the requirement to designate a primary care provider.

• If a plan requires that a primary care provider be designated for a child enrollee, the plan must permit the designation of a provider who specializes in pediatrics if the provider participates in the plan and is available to accept him.

• If a plan offers coverage for obstetrical or gynecological care and requires designation of an in-network primary care provider, the plan may not require a referral or authorization for a female enrollee who seeks those services from an in-network provider who specializes in obstetrical or gynecological care. The plan must inform enrollees that it may not require authorization or referral.

*Emergency Services:* If a plan provides any coverage for emergency services in an emergency department of a hospital, the plan must do so without requiring the individual or provider to obtain prior authorization, even if the emergency services are provided out of network. Emergency services are generally defined in accordance with EMTALA, though there are some variations (such as use of a prudent layperson standard rather than qualified hospital medical personnel standard).

Plans may not impose any administrative requirements or limitation on benefits for out-of-
network emergency services that are more restrictive than those that apply to in-network services. Co-payments and coinsurance for out-of-network emergency services may not be higher than the cost sharing that would have been imposed if the services were provided in-network. However, out-of-network providers may balance bill individuals for the difference between the providers’ charges and what they receive from the insurer plus the cost-sharing amount paid by the individual. This balance billing is not considered to be cost-sharing.

Plans must pay a reasonable amount for out-of-network emergency services. This is satisfied if the plan provides benefits for out-of-network emergency services equal to one of three possible amounts:

- The amount negotiated with in-network providers for the service provided
- The amount for the service calculated using the same method the plan generally uses to determine payment for out-of-network services (such as usual, customary, and reasonable charges), but using the in-network cost sharing rather than the out-of-network cost sharing
- The amount that would have been paid under Medicare for the same service

For plans that do not negotiate a per-service amount (such as capitated plans), the first option would not be available. For plans that negotiate different rates with different providers, the amount is the median of the negotiated rates.

The emergency services provisions do not apply to grandfathered plans.

**Issues for Children’s Hospitals**

Overall, the regulation includes many positive provisions that should result in providing more access to health care coverage to individuals with chronic and expensive illnesses. However, there are a few issues of concern to children’s hospitals that N.A.C.H. believes the regulations should address:

- **The choice-of-provider provision should define pediatrician broadly, to allow a pediatric specialist to be designated as a children’s primary care provider.** For children with complex and significant health needs, a pediatric specialist may be the provider who manages the child’s care, and thus more appropriately designated as the primary care provider than a general pediatrician.

- **The annual limits proposed in the regulation may not be sufficient for a child with complex health needs.** The regulation attempts to strike a balance between phasing out the use of annual limits on essential health benefits and mitigating the potential for increased premiums. However, it is important to consider whether the proposed annual limits over the three-year phase-out period are appropriate to cover the care for children with complex health needs.