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## **HEALTH CARE REFORM: NEW GUIDANCE ON PREEXISTING CONDITION EXCLUSIONS, LIFETIME AND ANNUAL LIMITS, RESCISSIONS, AND PATIENT PROTECTIONS**

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In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. These Acts (together the “Health Care Legislation”) were discussed in our recent Client Alert, [“Health Care Reform: Impact on Employers and Group Health Plans.”](#) Federal agencies, including the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services, are responsible for issuing guidance with respect to the Health Care Legislation. These agencies recently issued an interim final rule concerning the prohibition on preexisting condition exclusions, lifetime and annual dollar limits on benefits, restrictions on rescissions and patient protections.

The rules regarding preexisting condition exclusions, lifetime and annual dollar limits, and rescissions apply to all group health plans regardless of grandfathered plan status. The patient protection rules apply only to plans that are not considered grandfathered plans. For more information on grandfathered plan status, see our recent Client Alert, [“Health Care Reform: New Guidance on Early Retiree Reinsurance Program and Grandfathered Health Plans.”](#)

### **PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS**

Effective for plan years beginning on or after September 23, 2010, a group health plan will be prohibited from imposing any pre-existing condition exclusions for children who are under age 19. For plan years beginning on or after January 1, 2014, a group health plan will be prohibited from imposing any pre-existing condition exclusions for any individual regardless of age. The interim final rule clarifies that group health plans are prohibited from denying enrollment in the plan or specific benefit coverage based on the existence of a preexisting condition.

### **LIFETIME AND ANNUAL DOLLAR LIMITS**

Effective for plan years beginning on or after September 23, 2010, a group health plan will be prohibited from imposing lifetime dollar limits on “essential health benefits.” A plan may impose “restricted annual limits” on essential health benefits for plan years beginning before January 1, 2014; effective for plan years beginning on or after January 1, 2014, plans will be prohibited from imposing any annual limit on the dollar value of essential health benefits for any participant or beneficiary.

The Health Care Legislation provides that, with respect to benefits that are not essential health benefits, a group health plan may impose annual or lifetime per-individual dollar limits on specific

covered benefits. “Essential health benefits” will be defined further in future regulations, but must include at a minimum:

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

Until further regulations defining essential health benefits are issued, for purposes of enforcement, the federal agencies will take into account “good faith efforts” to comply with a reasonable interpretation of the term.

The interim final rule adopts a three-year phased approach for restricted annual limits. Annual limits on the dollar value of benefits that are essential health benefits may not be less than:

- \$750,000 for the plan year beginning on or after September 23, 2010 but before September 23, 2011
- \$1.25 million for the plan year beginning on or after September 23, 2011 but before September 23, 2012
- \$2 million for the plan year beginning on or after September 23, 2012 but before January 1, 2014

Individuals who have reached a lifetime limit under a group health plan who are otherwise still eligible for coverage must be given notice by the first day of the first plan year beginning on or after September 23, 2010 that lifetime limits no longer apply and that they have the right to re-enroll in the plan or switch benefit options. The Department of Labor has issued [model language for this notice](#).

## PROHIBITION ON RESCISSIONS

Effective for plan years beginning on or after September 23, 2010, a group health plan will be prohibited from rescinding an individual's coverage once the individual is covered under the plan, unless the individual has performed an act that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan. The interim final rule clarifies that the term "rescission" means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it has only a prospective effect or is due to failure to pay premiums in a timely manner. A group health plan must provide at least 30 days advance written notice to each participant whose coverage is going to be rescinded.

## PATIENT PROTECTIONS

Effective for plan years beginning on or after September 23, 2010, a non-grandfathered group health plan must satisfy certain requirements relating to choice of providers and emergency medical services.

With respect to choice of provider, the interim final rule provides:

- If a group health plan requires or provides for the designation of a primary care provider (PCP), it must permit each participant or beneficiary to designate any participating PCP who is available to accept the patient. For children, the plan must allow a pediatrician to be designated as the PCP.
- A group health plan cannot require any authorization or referral to access an OB/GYN provider.
- A group health plan must give notice of the choice of provider rules whenever the plan provides a participant with a summary plan description or other similar description of benefits. The Department of Labor has issued [model language for this notice](#). If a group health plan provides any benefits with respect to services in an emergency department of a hospital, the plan must provide for the services:
  - Without the need for any prior authorization determination, even for out-of-network services;
  - Without regard to whether the provider of the services is a participating network provider;
  - If the services provided are out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than those that apply to in-network services; and

- 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 under ERISA, the PHSA, or the Internal Revenue Code; or applicable cost sharing.

If the emergency services are provided out-of-network, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the out-of-network provider charges over the amount the group health plan is required to pay. A group health plan will be required to provide benefits with respect to emergency services in an amount equal to the greatest of three amounts, based on (1) the median charge for in-network services, (2) the amount calculated using the same method the plan generally uses to calculate out-of-network services, or (3) the Medicare reimbursement rate.

Please contact any of the attorneys listed below to discuss the impact the new law may have on your company's group health plan benefits.

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