

Summary of Interim Final Rule on Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

On June 28, 2010 the Departments of Health and Human Services (HHS), Labor and Treasury published a temporary regulation, or an [interim final rule](#), implementing the rules for group health plans (plan years beginning on or after September 23, 2010) for preexisting condition exclusions, lifetime and annual limits, rescission of coverage and patient protections. The rules are effective as of August 27, 2010 and comments are due on or before that date. A final rule will be subsequently published in the *Federal Register*.

Annual Limits

The rules regarding annual limits are particularly relevant to those restaurants who offer limited benefit plans, also known as “mini-med” plans, to their employees. These high-deductible plans are often offered to part-time, temporary or seasonal workers in the restaurant industry.

As of January 1, 2014, the PPACA prohibits annual limits of any kind, but this rule provides for a three year transition beginning in 2010. The rule states that a group health plan may not establish an annual limit on the dollar amount of benefits for any individual. However, plans are permitted to place annual limits on specific covered benefits that are not essential health benefits (to be further defined by the HHS Secretary) as long as such a limit is allowed under other applicable state or federal laws.

Prior to 2014, the following annual limits are permissible on essential health benefits:

- September 23, 2010 – September 23, 2011: \$750,000
- September 11, 2011 – September 23, 2012: \$1,250,000
- September 23, 2012 – September 23, 2014: \$2,000,000

The rule provides the Secretary of HHS the authority to establish a program where employers could apply to waive the requirement on restricted annual limits if the results would be a significant decrease in access to benefits or a significant increase in premiums. The interim final rule states that guidance regarding the scope and process for applying for such a waiver is expected in the “near future.”

Lifetime Limits

A group health plan may not establish lifetime limits on the dollar amount of benefits for any individual. However, plans are permitted to place lifetime limits on specific covered benefits that are not essential health benefits (to be further defined by the HHS Secretary) as long as such a limit is allowed under other applicable state or federal laws.

Preexisting Condition Exclusions

All group health plans (including grandfathered group health plans) may not impose preexisting condition exclusions effective January 1, 2014. Grandfathered plans can not

impose preexisting condition exclusions for children under the age of 19 for plan years beginning on or after September 23, 2010.

Rescissions

The rule defines rescission as a cancellation or discontinuance of coverage retroactively. A group health plan (including grandfathered group health plans) can not rescind coverage unless an enrollee commits fraud or makes an intentional misrepresentation of material fact. Before rescinding coverage, the plan must provide the enrollee at least 30 days written notice to each participant who would be affected. Further guidance on any notice requirements is expected. Notice is required regardless of whether the coverage is insured or self-insured, and applicable to an entire group or just an individual.

These rules apply to plan years beginning on or after September 23, 2010.

Patient Protections

The interim final rule also lays out the rules for group health plans as it applies to choice of health care professional for those plans with a network of providers, and requirements for emergency services benefits.

A group health plan with a network of providers must allow enrollees to designate their primary care provider, including a pediatrician as a primary care provider. Patients must also have access to obstetrical and gynecological care without referrals. The rule goes beyond the status and requires plans to inform enrollees of their right to designate a primary care provider.

The rule requires group health plans to provide emergency services benefits without prior authorization and without regard of whether the provider is in-network. Plans are allowed to deny emergency services benefits only because of: exclusion or coordination of benefits, a permitted affiliation or waiting period, or applicable cost-sharing requirement. Administrative requirements or limitations of emergency services benefits can not be greater than those imposed on in-network emergency services. The regulation also establishes rules for cost-sharing requirements such as copayments or coinsurance.

Grandfathered group health plans are not subject to neither the choice of health care professional nor emergency services benefits requirements. However, other federal or state laws may apply regardless of grandfathered status.