Interim Final Rule re: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections

Preexisting Conditions

- The regulations prohibiting preexisting condition exclusions is effective for group health plans after January 1, 2014, but is effective for children under age 19 starting September 23, 2010.
- Prohibits exclusion of coverage for specific treatment associated with a preexisting condition and complete denial of coverage for a preexisting condition.
- It is not a preexisting condition exclusion to exclude benefits for a condition regardless of when the condition arose.
- Group grandfathered health plans must comply with the preexisting condition provisions, but grandfathered individual health insurance plans need not do so.

Lifetime and Annual Limits

- Prohibits lifetime limits on "essential health benefits" in group plans for plan years starting on or after September 23, 2010.
- Individuals who have exceeded a plan's existing lifetime limits under the old rules (but who would otherwise be eligible for coverage) must be notified that they will again become eligible for benefits and be given at least a 30-day period to reenroll in the plan.
- Prohibits annual limits on "essential health benefits" in group plans starting on or after January 1, 2014.
- Restricted annual limits allowed for essential health benefits for plan years beginning before January 1, 2014, according to the following schedule:
    - Limits of not less than $750,000 for plans beginning between 9/23/10 and 9/23/11;
    - Limits of not less than $1.25 million for plans beginning between 9/23/11 and 9/23/12; and
    - Limits of not less than $2 million for plans beginning between 9/23/12 and 1/1/14.
    - These minimum annual limits apply on an individual-by-individual basis, not a family basis.
- The prohibition against restricting annual limits does not apply to health FSAs, MSAs, HSAs, HRAs integrated with other coverage as part of a group health plan and stand-alone retiree-only HRAs.
- The regulation does not address whether or not a stand-alone HRA that is not a retiree-only HRA is subject to the lifetime/annual limit restrictions.
- In applying annual limits for plan years starting before January 1, 2014, the plan may take into account only essential health benefits.
- Only grandfathered individual plans are exempt from the annual limit prohibition.

- A plan may impose annual or lifetime per-individual limits on non-essential health benefits.
- Until regulations defining "essential health benefits" are promulgated, a plan must apply its definition of an "essential health benefit" consistently.
- An exclusion of all benefits for a condition is not considered to be an annual or lifetime limit.
- Limited benefit plans can apply to HHS for a waiver from the annual limit restrictions if the plan can establish that the annual limits are necessary to prevent a significant loss of coverage or increase in premiums.
- A plan loses grandfather status if:
    - It adds an overall annual limit and did not have annual limit or lifetime limit as of March 23, 2010;
    - It lowers its annual limit below the lifetime limit value existing on March 23, 2010;
    - It decreases its annual limit below the annual limit existing on March 23, 2010.

Coverage Rescission

- A group plan cannot rescind coverage unless there is fraud or intentional misrepresentation of a material fact.
- An individual must be provided with a 30 day notice before coverage is rescinded.
- A rescission is treated as a retroactive cancellation or discontinuance of coverage.
- A prospective cancellation is not a rescission.
- A retroactive cancellation for failure to pay premiums is not a rescission.
- The restrictions on coverage rescissions are effective for plan years beginning on or after September 23, 2010, and apply to grandfathered and non-grandfathered plans.

Patient Protections

- If a plan requires a PCP, then the beneficiary can designate any PCP or Pediatrician as his or her PCP.
- Prohibits prior authorization or referral when a beneficiary seeks obgyn care from a participating obgyn.
- Prohibits prior authorization for ER services.
- Out-of-network ER copays/coinsurance cannot be greater than those for in-network ERs.
- These patient protection provisions only apply to non-grandfathered plans and are effective starting September 23, 2010.