

To: Our Clients and Friends

June 30, 2010

## Regulations Issued on Preexisting Condition Exclusions, Annual and Lifetime Limits, Rescissions and Patient Protections Under Health Care Reform

On June 22, 2010, the Departments of Labor, Treasury and Health & Human Services issued regulatory guidance under the Patient Protection and Affordable Care Act (the "Act") regarding prohibitions on preexisting condition exclusions, annual and lifetime limits and rescissions, as well as guidance regarding certain patient protections.

These rules are generally effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). Grandfathered group health plans must comply with the prohibitions on preexisting condition exclusions, lifetime and annual limits and rescissions, but are exempt from the rules regarding patient protections. For a review of the rules governing grandfathered plans, please see our previous Employee Benefits and Executive Compensation [Bulletin](#).

### Prohibition on Preexisting Condition Exclusions

The Act prohibits preexisting condition exclusions in group health plans for enrollees who are 19 years of age or younger, effective for plan years beginning on or after September 23, 2010. This prohibition will extend to all enrollees as of January 1, 2014. Until the regulations are effective, the current preexisting condition rules will continue to apply. An exclusion of benefits for a particular condition is not a preexisting condition exclusion if it applies regardless of when the condition arose relative to the date of coverage.

### Prohibition on Lifetime or Annual Limits

The Act prohibits a group health plan from imposing lifetime limits on "essential health benefits" for plan years beginning on or after September 23, 2010, and from imposing annual dollar limits on any such benefits for any individual for plan years beginning on or after January 1, 2014. Regulations defining essential health benefits have yet to be released, but the Act provides a non-exclusive list of these benefits, which includes the following: ambulatory and emergency services, hospitalization, maternity and newborn care, mental health, prescription drugs, lab services, chronic disease management and pediatric services.

While the prohibition on annual limits does not apply until 2014, the regulations require that the annual dollar limits for plan years beginning prior to January 1, 2014 not be less than the following amounts:

- \$750,000 for plan years beginning on or after September 23, 2010 and before September 23, 2011.
- \$1,250,000 for plan years beginning on or after September 23, 2011 and before September 23, 2012.
- \$2,000,000 for plan years beginning on or after September 23, 2012 and before September 23, 2013.

If an individual has lost coverage on account of a plan's lifetime limit and becomes eligible again for coverage due to the prohibition on lifetime limits, the plan or insurer must provide the individual with written notice that the limit no longer applies and that the individual is eligible for benefits.

The regulations clarify that the prohibition on annual and lifetime limits does not prevent a group health plan from excluding all benefits for a particular condition, as that is not considered an annual or lifetime limit. However, note that adding a condition exclusion may not only cause a plan to lose its grandfathered status, but also could implicate other federal laws. In addition, these limits do not apply to health flexible spending arrangements (FSA), medical savings accounts (MSA) or health savings accounts (HSA).

### **Prohibition on Rescissions**

The Act prohibits a group health plan from rescinding an individual's coverage, except in the case of fraud, or intentional misrepresentation of material fact. A rescission is defined as a retroactive cancellation or discontinuance of coverage. Cancellation of coverage that only has prospective effect, or a cancellation that is retroactively effective due to a failure to pay required premiums will not be treated as a rescission and will continue to be permissible. In these cases, the regulations require that plans give each affected participant at least 30 days prior notice before rescission in order to give plan sponsors and participants a chance to explore rights and contest the rescission.

### **Patient Protection Rules**

The following rules apply to plans other than grandfathered plans:

- Plans with a network of providers requiring designation by a participant or beneficiary of a participating primary care physician must provide notice of the terms of the plan regarding such designation, which include the right to designate any available, in-network primary care physician, and to designate any in-network pediatrician as the primary care provider for children.
- Plans with a network of providers that provide obstetrical or gynecological care and require the designation of an in-network primary care physician may not require women participants or beneficiaries to obtain an authorization or referral before seeking such care provided by an in-network OB/GYN.
- Plans providing emergency services benefits may not require prior authorization (even if the emergency services are provided out-of-network), be limited to in-network providers, or impose more restrictive requirements or limitations on access to or cost-sharing for out-of-network emergency services.

Plans that do not negotiate with providers for the delivery of health care, but merely reimburse participants for their receipt of health care are not subject to requirements regarding choice of health care professional, but are subject to the requirements regarding emergency services.

The attorneys of the Employee Benefits and Executive Compensation group of Bryan Cave LLP are available to answer your questions.

<b>Richard (Rick) L. Arenburg</b>	(404) 572-6765	<a href="mailto:richard.arenburg@bryancave.com">richard.arenburg@bryancave.com</a>
<b>Brian W. Berglund</b>	(314) 259-2445	<a href="mailto:bwberglund@bryancave.com">bwberglund@bryancave.com</a>
<b>Harold G. Blatt</b>	(314) 259-2216	<a href="mailto:hgblatt@bryancave.com">hgblatt@bryancave.com</a>
<b>Armin G. Brecher</b>	(404) 572-6634	<a href="mailto:armin.brecher@bryancave.com">armin.brecher@bryancave.com</a>
<b>Bard Brockman</b>	(404) 572-4507	<a href="mailto:bard.brockman@bryancave.com">bard.brockman@bryancave.com</a>
<b>Carrie E. Byrnes</b>	(312) 602-5063	<a href="mailto:carrie.byrnes@bryancave.com">carrie.byrnes@bryancave.com</a>
<b>Paul F. Concannon</b>	(404) 572-6856	<a href="mailto:paul.concannon@bryancave.com">paul.concannon@bryancave.com</a>
<b>Chad R. DeGroot</b>	(314) 259-2803	<a href="mailto:chad.degroot@bryancave.com">chad.degroot@bryancave.com</a>
<b>Edmund (Ed) Emerson</b>	(404) 572-6739	<a href="mailto:edmund.emerson@bryancave.com">edmund.emerson@bryancave.com</a>
<b>Jennifer Faucett</b>	(404) 572-4516	<a href="mailto:jennifer.faucett@bryancave.com">jennifer.faucett@bryancave.com</a>
<b>Kyle P. Flaherty</b>	(212) 541-2134	<a href="mailto:kpflaherty@bryancave.com">kpflaherty@bryancave.com</a>
<b>Mark H. Goran</b>	(314) 259-2686	<a href="mailto:mhgoran@bryancave.com">mhgoran@bryancave.com</a>
<b>Carrie E. Herrick</b>	(314) 259-2212	<a href="mailto:carrie.herrick@bryancave.com">carrie.herrick@bryancave.com</a>
<b>Jonathan Hull</b>	(314) 259-2359	<a href="mailto:jthull@bryancave.com">jthull@bryancave.com</a>
<b>Charles B. Jellinek</b>	(314) 259-2138	<a href="mailto:cbjellinek@bryancave.com">cbjellinek@bryancave.com</a>
<b>Michele L. Lux</b>	(314) 259-2519	<a href="mailto:mllux@bryancave.com">mllux@bryancave.com</a>
<b>Hal B. Morgan</b>	(314) 259-2511	<a href="mailto:hbmorgan@bryancave.com">hbmorgan@bryancave.com</a>
<b>Dan O'Keefe</b>	(314) 259-2179	<a href="mailto:dmokeefe@bryancave.com">dmokeefe@bryancave.com</a>
<b>Christian Poland</b>	(312) 602-5085	<a href="mailto:christian.poland@bryancave.com">christian.poland@bryancave.com</a>
<b>Kathy Reardon</b>	(314) 259-2269	<a href="mailto:kcreardon@bryancave.com">kcreardon@bryancave.com</a>
<b>Jeffrey S. Russell</b>	(314) 259-2725	<a href="mailto:jsrussell@bryancave.com">jsrussell@bryancave.com</a>
<b>Christopher (Chris) Rylands</b>	(404) 572-6657	<a href="mailto:chris.rylands@bryancave.com">chris.rylands@bryancave.com</a>
<b>Michael G. Salters</b>	+44-20-7246-5844	<a href="mailto:michael.salters@bryancave.com">michael.salters@bryancave.com</a>
<b>Steven G. (Steve) Schaffer</b>	(404) 572-6830	<a href="mailto:steven.schaffer@bryancave.com">steven.schaffer@bryancave.com</a>
<b>Kathleen R. Sherby</b>	(314) 259-2224	<a href="mailto:krsherby@bryancave.com">krsherby@bryancave.com</a>
<b>Sarah Roe Sise</b>	(314) 259-2741	<a href="mailto:srsise@bryancave.com">srsise@bryancave.com</a>
<b>Michael Corey Slagle</b>	(214) 721-8031	<a href="mailto:corey.slagle@bryancave.com">corey.slagle@bryancave.com</a>
<b>Alan H. Solarz</b>	(212) 541-2075	<a href="mailto:ahsolarz@bryancave.com">ahsolarz@bryancave.com</a>
<b>Jennifer W. Stokes</b>	(314) 259-2671	<a href="mailto:jennifer.stokes@bryancave.com">jennifer.stokes@bryancave.com</a>
<b>Lisa A. Van Fleet</b>	(314) 259-2326	<a href="mailto:lavanfleet@bryancave.com">lavanfleet@bryancave.com</a>
<b>Tom Wack</b>	(314) 259-2182	<a href="mailto:tewack@bryancave.com">tewack@bryancave.com</a>
<b>Julie A. Wagner</b>	(314) 259-2637	<a href="mailto:jawagner@bryancave.com">jawagner@bryancave.com</a>
<b>Jay P. Warren</b>	(212) 541-2110	<a href="mailto:jpwarren@bryancave.com">jpwarren@bryancave.com</a>
<b>Carolyn Wolff</b>	(314) 259-2206	<a href="mailto:carolyn.wolff@bryancave.com">carolyn.wolff@bryancave.com</a>
<b>Serena F. Yee</b>	(314) 259-2372	<a href="mailto:sfyee@bryancave.com">sfyee@bryancave.com</a>

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