

## **HHS Releases Final Interim Guidance on Several PPACA Provisions**

On June 22, 2010, the Departments of Health & Human Services, Labor, and Treasury issued new regulations that better define the following PPACA provisions:

- No Pre-Existing Condition Exclusions for Anyone Under Age 19
- No Arbitrary Rescissions of Insurance Coverage
- No Lifetime Dollar Limits on Coverage
- Restricted Annual Dollar Limits on Coverage
- Broader Doctor Choice
- No Higher Out-of-Network Cost-Share for Emergency Department Services

These are labeled as interim final rules (IFRs), which means final rules may differ. As clarification continues to be provided through the federal government's rule-making process, we'll share that information with you. Please continue to look out for e-mail Alerts and information on our Health Care Reform website on these important subjects.

### **All provisions are effective on the first plan anniversary on or after 9/23/2010**

#### **No Pre-Existing Condition Exclusions for Anyone Under Age 19**

Plans are prohibited from denying coverage to anyone under the age of 19 based on a pre-existing condition. This ban includes both benefit limitations and coverage denials. These policies apply to all individual market and group health insurance plans. The requirement will be extended to all ages starting in 2014. Grandfathered individual plans are exempt from this requirement.

#### **No Arbitrary Rescissions of Insurance Coverage**

Insurers and plans will be prohibited from rescinding coverage – for individuals or groups of people – except in cases involving fraud or an intentional misrepresentation of material facts.

#### **No Lifetime Dollar Limits on Coverage**

Insurers and employers are prohibited from imposing lifetime dollar limits in all health plans and insurance policies issued or renewed on or after September 23, 2010.

#### **Restricted Annual Dollar Limits on Coverage**

The rules will phase out the use of annual dollar limits on “essential health benefits” over the next three years until 2014 when the Affordable Care Act bans them for most plans. The limits can only apply to essential health benefits; however, the rule does not provide any further detail on the definition of “essential health benefits” beyond that provided in the law.

- Plans issued or renewed beginning September 23, 2010, will be allowed to set annual limits no lower than \$750,000
- Beginning September 23, 2011, minimum limit will be raised to \$1.25 million
- Beginning September 23, 2012, minimum limit will be raised to \$2 million
- Beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited

These limits apply to all employer plans and all new individual market plans. It does not apply to grandfathered individual plans.

**Waiver Process/Special Consideration:**

The IFRs indicate that the Health & Human Services Secretary will design a process by which employers and insurers may apply for a waiver to delay complying with the restricted annual dollar limit rules if compliance would cause a significant loss of coverage or increase in premiums. The IFRs indicate that limited medical plans (such as CIGNA Voluntary) are one example of the type of plan that may apply for a waiver. We await details from the Secretary about the waiver application process.

*The waiver for special circumstances reflects the Administration's desire to work with the industry to minimize disruption during the transition period from now to 2014, and is a direct result of CIGNA's efforts to work with the Administration on the implementation of the Patient Protection and Affordable Care Act, and of the letters that many Limited Medical clients wrote to Congress and HHS.*

**Broader Doctor Choice**

Health plan members are free to designate any available participating primary care physician (PCP) as their provider (e.g., pediatricians for children). Also, plans cannot require a referral for OB-GYN care.

These policies apply to all individual market and group health insurance plans except those that are grandfathered.

**No Higher Out-of-Network Cost-Share for Emergency Department Services**

Health plans and insurers will not be able to charge higher cost-sharing (copays or coinsurance) or require prior authorization for emergency services that are obtained out of a plan's network. This policy applies to all individual market and group health plans except those that are grandfathered.