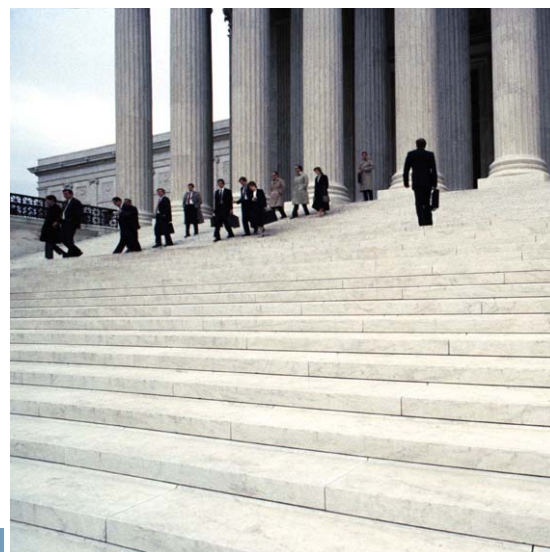


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Health Care Reform: Interim Final Rules on a Patients' Bill of Rights



EXECUTIVE SUMMARY

The Departments of Treasury, Labor (DOL) and Health and Human Services (HHS) have issued interim final rules related to the provisions of the Patient Protection and Affordable Care Act (PPACA) regarding pre-existing condition exclusions, lifetime and annual limits, rescissions and other patient protections. Most of these provisions are effective for plan years beginning on or after **September 23, 2010**.

Plan sponsors should become familiar with these requirements in order to determine whether the new rules apply to their plans and whether their plans must be amended accordingly.

This FAS-EBA, Inc. Legislative Brief describes the provisions of PPACA regarding these rules, as well as the clarifications made by the interim final rule. Please read below for more information.

EXPLANATION OF THE INTERIM FINAL RULE

Pre-existing Condition Exclusions

PPACA prohibits any pre-existing condition exclusions from being imposed by group health plans or group health insurance coverage, including grandfathered group health plans. PPACA also extends this prohibition to individual health insurance coverage, although it does not apply to grandfathered individual policies.

This prohibition generally is effective with respect to plan years beginning on or after **January 1, 2014**. However, for enrollees who are under 19 years of age, this prohibition takes effect for plan years beginning on or after **September 23, 2010**.

A pre-existing condition exclusion is a limitation or exclusion of benefits related to a condition, based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Based on this definition, PPACA prohibits exclusions of coverage of specific benefits and a complete exclusion from a plan based on a pre-existing condition.

Until these new rules take effect, the rules regarding pre-existing condition exclusion rules in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will continue to apply. The rules do not change the HIPAA rule that an exclusion of benefits for a certain condition under a plan is not a pre-existing condition exclusion if the exclusion is not based on the date the condition arose.

Lifetime and Annual Limits

PPACA generally prohibits group health plans, and group and individual health insurance issuers, from imposing lifetime or annual limits on the dollar value of health benefits, effective for plan years beginning on or after **September 23, 2010**. Although annual limits are generally prohibited, "restricted annual limits" are permitted for essential health benefits for plan years beginning before January 1, 2014.

Restricted Annual Limits

The interim final rules establish a three-year phased approach for restricted annual limits. Annual limits may not be less than the following amounts for plan years beginning before January 1, 2014:

- \$750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;

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- \$1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and
- \$2 million for plan years beginning on or after September 23, 2012, but before January 1, 2014.

These are minimums for plan years; plans may use higher annual limits or impose no limits. The limits apply on an individual-by-individual basis, so that any annual limit on benefits applied to families cannot cause an individual to be denied the minimum annual benefit for the plan year.

The restricted annual limits are designed to ensure that individuals would have access to needed services with a minimal impact on premiums. However, they could affect limited benefit plans or "mini-med" plans. Therefore, the interim final rule provides for the establishment of a program for waiving the annual limit restrictions if they would cause a significant decrease in access to benefits or increase in premiums. HHS is expected to issue guidance regarding these waivers in the near future.

Covered Plans

The prohibition on lifetime and annual limits applies to both new and grandfathered group health plans. However, it does not apply to grandfathered individual policies. The restrictions on annual limits do not apply to account-based plans like health flexible spending arrangements (health FSAs), medical savings accounts (MSAs), health savings accounts (HSAs) and health reimbursement arrangements (HRAs).

Essential Health Benefits

PPACA specifically provides that plans may impose annual or lifetime per-individual limits on specific covered benefits that are not "essential health benefits." Regulations still need to be issued on the definition of essential health benefits, but it will include at least the following general categories of items and services:

- 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;
- Preventive and wellness services, including chronic disease management; and
- Pediatric services, including oral and vision care.

Until those regulations are issued, plans can use a good faith effort to comply with a reasonable interpretation of essential health benefits and must apply it consistently.

The interim final rules clarify that a plan can still exclude all benefits for a condition. Such an exclusion will not be considered an annual or lifetime limit as long as no benefits are provided for the condition.

Enrollment Opportunities

Under the interim final rules, individuals who reached a lifetime limit prior to the date the regulations are effective and are otherwise eligible for plan coverage must be given a notice that the lifetime limit no longer applies. They must also be permitted to re-enroll in the plan if they are no longer enrolled. The notices and enrollment opportunity must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Anyone who is eligible for the enrollment opportunity must be treated as a special enrollee who is eligible to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

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Rescissions

PPACA and the interim final rules place limits on the ability of a group health plan, or group and individual health insurance issuer, to rescind health coverage. Effective for plan years beginning on or after **September 23, 2010**, coverage may be rescinded only in the case of fraud or intentional misrepresentation of a material fact. Fraud may include an omission of relevant facts. This standard applies to all rescissions, whether in the group or individual market, and whether the coverage is insured or self-funded. If a state law is more protective of individuals than the federal law, the state law will continue to apply.

For purposes of the interim final rule, a rescission is a cancellation or discontinuation of coverage that has a retroactive effect. For example, a cancellation that treats a policy as void from the time of enrollment is a rescission. Prospective cancellations and retroactive cancellations due to a failure to pay required premiums would not be considered rescissions.

The prohibition on rescissions applies whether the rescission applies to an individual, an individual within a family, or an entire group of individuals. The rules on rescissions also apply to representations made by the individual or a person seeking coverage on behalf of the individual, such as the plan sponsor.

In addition to setting federal requirements for rescissions, PPACA adds a new advance notice requirement when coverage is rescinded where still permissible. Group health plans and group health insurance issuers must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded. This 30-day period will provide individuals and plan sponsors with an opportunity to contest the rescission or look for alternative coverage.

The rules regarding rescission and advance notice apply to all grandfathered health plans.

Patient Protections

PPACA imposes three new requirements on group health plans and group or individual health insurance coverage that are referred to as "patient protections." These patient protections relate to the choice of a health care professional and benefits for emergency services and are effective for plan years beginning on or after **September 23, 2010**. They do not apply to grandfathered plans. The rules regarding choice of health care professional apply only to plans that have a network of providers.

Choice of Primary Care Provider

If a group health plan, or group or individual health insurer, requires a participant to designate a primary care provider, the participant must be able to choose any participating primary care provider who is able to accept the participant as a patient. This rule includes a pediatrician as the primary care provider for a child. The plan must provide a notice informing each participant of the plan's terms regarding primary care provider designation. The notice should be included in the plan's summary plan description. The interim final rules include model language for this notice.

OB/GYN Care

Plans that provide coverage for obstetrical and/or gynecological care (ob/gyn care) and require the patient to designate an in-network primary care provider may not require preauthorization or referral for a female participant seeking such care. The plan must inform each participant of these rules and should include the notice in its summary plan description. Model language is included in the interim final rules. A plan may still require the ob/gyn provider to follow any policies or procedures regarding referrals, prior authorization for treatments and the provision of services.

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Emergency Services

PPACA places additional requirements on plans and health insurance issuers that provide hospital emergency room benefits. Plans and issuers must provide those benefits without requiring prior authorization and without regard to whether the provider is an in-network provider.

Also, the plan or issuer may not impose requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network emergency services. Cost sharing requirements, such as copayments or coinsurance rates, imposed for out-of-network emergency services cannot exceed the cost-sharing requirements for in-network emergency services.

Despite this rule, out-of-network providers may balance bill patients, as long as the plan or issuer has paid a reasonable amount for the services. The interim final rules provide guidance on determining whether the amount paid is reasonable. Also, other cost-sharing requirements, such as deductibles or out-of-pocket maximums, may be imposed on out-of-network emergency services if the cost-sharing requirement generally applies to out-of-network benefits.

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