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The Next Wave of PPACA Guidance Hits Shore – Interim Final Rules Cover Lifetime/Annual Limits, Rescissions, and Patient Protections

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New interim final rules from the Departments of Treasury, Labor, and Health and Human Services will help employers navigate a series of changes under the Patient Protection and Affordable Care Act (PPACA or the Act) that include standards on lifetime and annual benefit limits, retroactive rescissions of plan coverage, and emergency room services. President Barack Obama dubbed this set of rules the "Patient's Bill of Rights."

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Published in the *Federal Register* on June 28, 2010, these rules focus on four provisions added by the PPACA to the Public Health Services Act (PHSA):

Prohibition on Preexisting Condition Exclusions or Other	PHSA §2704
Discrimination Based on Health Status	
No Lifetime or Annual Limits	PHSA §2711
Prohibition on Rescissions	PHSA §2712
Patient Protections	PHSA §2719A

This guidance follows earlier guidance under the PPACA on the coverage of adult children (see the May 12, 2010 issue of the *Benefits eAuthority*) and the application of the grandfathering provisions of the health care

reform law (see the June 21, 2010 issue of the *Benefits eAuthority*).

No Lifetime or Annual Limits

Under current law, group health plans are allowed to contain lifetime or annual dollar limits on the amount of benefits the plan will cover. The Act generally prohibits imposing lifetime or dollar limits on "essential health benefits" for plan years beginning on or after September 23, 2010. A complete ban on lifetime or annual limits takes effect January 1, 2014. Note that these limitations apply differently to certain account-based plans, such as health flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs), which have their own specific statutory provisions.

The regulations provide that a group health plan may impose a lifetime or annual limit only with respect to any individual on specific covered benefits that are not "essential health benefits," and only to the extent such limits are otherwise permitted under federal or state law. However, the regulations define the term "essential health benefits" to include the rather comprehensive list contained in Section 1302(b) of the PPACA – ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, laboratory services, preventative and wellness services, chronic disease management, and pediatric services, including oral and vision care. The preamble indicates that the Departments will take into account a "good faith effort" to comply with a reasonable interpretation of the term "essential health benefits" until regulations are issued. Group health plans also may exclude all benefits for a condition. However, if any benefits are provided for a condition, then the prohibition on lifetime or annual limits applies to *all* benefits associated with that condition.

The regulations provide for a three-year phased approach by restricting the annual limits on essential health benefits that are permissible before January 1, 2014, as follows:

Plan Year (for calendar year plans)	Annual Limit
2011	$750,000
2012	$1,250,000
2013	$2,000,000

The regulations also contain a "waiver" provision for plan years beginning before January 1, 2014, for group health plans that have annual dollar limits below the restricted annual limits in the table above, if compliance with the restricted limits would result in a significant decrease in access to benefits (or coverage) under the plan or would significantly increase premiums for the plan (or health insurance coverage).

The preamble to the regulations also includes a specific reference to limited benefit plans or so-called "mini-med" plans, and states that the regulations provide for the Secretary of Health and Human Services to establish a program under which the restricted annual limits could be waived. This is particularly important for employers with large populations of part-time workers, such as restaurant and hotel chains, who provide their part-time employees with these limited benefit or mini-med plans.

Notice Requirements

For individuals who reach a lifetime limit before the new PPACA rules take effect, a plan or insurer is required to notify the individual that the lifetime limit on the dollar value of all benefits no longer applies, and the individual, if otherwise eligible, is once again eligible for benefits under the plan. If the individual is not enrolled under the plan, he or she must be considered a special enrollee and given the opportunity to enroll that continues for at least 30 days. The notice and enrollment opportunity must be provided beginning no later than the first day of the first plan year beginning on or after September 23, 2010. Note that the 30-day notice requirement lines up nicely with the notice employers or health insurance issuers are required to give to individuals about their ability to cover their adult children up to age 26. Therefore, employers may be able to reduce the administrative burden associated with these notices by conducting a 30-day open enrollment period for their next plan year.

This provision is effective for plan years that begin on or after September 23, 2010, and applies to group health plans and insurers, including grandfathered plans.

Impact on Grandfathered Status

The preamble to the regulations points out that these rules apply to grandfathered plans as well. Note that under the interim final rule on grandfathering published June 17, 2010, a group health plan can lose its grandfathered status by imposing a limit that was not in existence on March 23, 2010, or decreasing a limit that was in effect on March 23, 2010. However, because grandfathered plans are subject to the "no lifetime or annual limit" provision, presumably, if a grandfathered plan that had an annual limit lower than the $750,000 restricted limit for 2011, increased its limit to $750,000 to bring it into compliance, it should not lose its grandfathered status. However, if a plan did not have an annual limit in place on March 23, 2010, it may not impose a $750,000 limit without losing its grandfathered status.

Prohibition on Rescissions

One of the most perplexing provisions contained in the PPACA is the prohibition on rescissions. A literal reading of the provision had employers and practitioners scratching their heads as to when it could ever be appropriate to rescind coverage under the Act. The regulations provide much needed clarification that the term "rescission" means a retroactive cancellation or discontinuance of coverage. For example, a cancellation that voids benefits paid up to a year before the cancellation is a rescission. The regulations provide that a

cancellation or discontinuance of coverage is not a rescission if it has only a prospective effect or is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

In addition, the no rescission provision adds a new advance notice requirement when coverage is rescinded. A group health plan or insurer must provide at least 30 calendar days advance notice to an individual before coverage is rescinded. This 30-day period would give individuals the chance to contest the rescission or look for alternative coverage.

The prohibition on rescissions applies to fully-insured and self-insured plans, as well as grandfathered plans, and is effective for plan years beginning on or after September 23, 2010.

Prohibition on Preexisting Condition Exclusions

Prior to the Act, group health plans and health insurance issuers were allowed to incorporate limited preexisting condition exclusions into their plans, provided the exclusions complied with the portability and nondiscrimination rules under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA generally defines a preexisting condition exclusion as a limitation or exclusion of benefits relating 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. (For example, a group health plan could contain a 12-month pre-existing condition exclusion for asthma if a new enrollee did not provide a certificate of creditable coverage.) The Act prohibits this practice for children under age 19 for plan years beginning on or after September 23, 2010, and prohibits imposition of preexisting condition exclusions entirely beginning January 1, 2014. All group health plans and health insurers, even if grandfathered, must comply with this rule.

Patient Protections

New Section 2719A of the PHSA contains three patient-focused provisions designed to simplify access to certain types of care with respect to plans or health insurance coverage with a network of providers.

Choice of Health Care Professional

If a group health plan or health insurer requires that the participant or enrollee designate a participating primary care provider, then the plan or insurer must permit each participant or enrollee to choose any provider who is available to accept the patient. Similarly, in the case of a child, the plan or issuer must permit the participant or beneficiary to choose a pediatrician as the primary care provider for the child.

Obstetrics and Gynecological Referrals

A group health plan or health insurer also may not require authorization or referral for a female participant or enrollee who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in obstetrics and gynecology. The regulations clarify that this professional need not be a doctor.

Emergency Care

Group health plans or health insurers may not require a prior authorization for emergency care (even if out-of-network) or impose any requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services from an in-network provider. Also, any cost-sharing component of the fee may not exceed the cost-sharing component of the fee if the care were obtained in-network. However, the regulations clarify that out-of-network providers may "balance bill" the patient for the difference between the provider's charges and what has been paid by the plan and the patient in the form of a copayment or coinsurance.

Notice Requirement

In addition, a group health plan or insurer must provide notice to participants that they have a right to designate a primary care provider of their choice, that they have the right to designate a pediatrician as the primary care provider of a child, and that authorization or referral may not be required for obstetrical or gynecological care. The notice can be included in the summary plan description or other similar description of benefits under the plan or health insurance coverage. The regulations provide model language plans may use to satisfy the notice requirement.

These patient protection provisions are applicable to group health plans and health insurers effective for plan years beginning on or after September 23, 2010. However, these rules to not apply to grandfathered plans.

TOPICS

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