

**Health Care Reform:
Patient's Bill of Rights – Regulations Part I**

July 2010

On June 28, 2010, regulations were published for the Patient Protection and Affordable Care Act (PPACA). The White House has referred to these regulations as the new Patient's Bill of Rights. Included in the regulations are prohibitions on exclusions for preexisting conditions, certain annual and lifetime limits and rescissions of coverage. Additionally, the regulations require that non-grandfathered plans provide certain patient protections with respect to access to coverage and emergency services.

This *Briefing* describes the regulations referred to as the new Patient's Bill of Rights as issued. As with earlier regulations issued under PPACA, many questions are still left unanswered. Additional information regarding PPACA is available on Keenan's Web site at <http://www.keenan.com/press/hcReform2010.asp>.

PROHIBITION ON PREEXISTING CONDITIONS – ALL PLANS

Plan Years Beginning on or After September 23, 2010 – All group health plans, including grandfathered plans, may not impose any preexisting condition limitation on children under age 19.

Plan Years Beginning on or After January 1, 2014 – Group health plans may not impose any preexisting condition limitations, irrespective of age.

Health Insurance Portability and Accountability Act (HIPAA) Rules – Previous rules under HIPAA remain unchanged with respect to a plan's ability to completely exclude benefits for a condition, if the exclusion applies whether or not there is a preexisting condition.

LIFETIME AND ANNUAL LIMITS – ALL PLANS

For plan years beginning on or after September 23, 2010, group health plans, including grandfathered plans, may not impose lifetime limits on the dollar value of essential health benefits¹. Restricted annual limits on the dollar value of essential health benefits are permitted for plan years beginning before January 1, 2014.

- With respect to benefits that are not essential health benefits, sponsors may impose per-individual annual or lifetime dollar limits on specific covered benefits. Regulations have not been issued about essential health benefits but plan sponsors who make a good faith effort to comply with a reasonable interpretation of what is an essential health benefit should satisfy these rules.

¹ "Essential health benefits" are described in PPACA as including at least the following general categories and the items and services covered within the categories: 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 and chronic disease management; and pediatric services, including oral and vision care.

- There is a three-year phased-in approach with respect to overall annual dollar limits on essential health benefits. Annual limits for plan years beginning on or after September 23, 2010 may not be less than \$750,000 and for the next two successive plan years, \$1.25 million and \$2 million, respectively.
- Account-based plans are generally excluded from this rule because they are subject to limits imposed by other laws.
- Plans remain subject to other State and Federal laws that impose additional restrictions on annual and lifetime limits.
- Notice must be given to individuals who have already reached their lifetime limit that the lifetime limit no longer applies.

INTEGRATION OF THE PATIENT'S BILL OF RIGHTS WITH GRANDFATHER PLAN REGULATIONS

Although the Patient's Bill of Rights allows plans to impose restricted annual limits on essential health benefits, group health plans could lose their grandfather status if any of the following occurs:

- A group health plan that has an overall lifetime limit on the dollar value of all benefits, but not an overall annual limit on the dollar value of all benefits, will lose its grandfather status if it adopts an overall annual limit at a dollar value that is lower than the lifetime limit.
- A group health plan that imposes an overall annual limit on the dollar value of all benefits will lose grandfather status if it decreases the dollar value of the annual limit (whether or not it has a lifetime limit).
- A group health plan that imposes no overall lifetime or annual limits of the dollar value of all benefits loses its grandfather status if it imposes an overall annual limit on the dollar value of all benefits.

RESCISSIONS OF COVERAGE – ALL PLANS

For plan years beginning on or after September 23, 2010, a group health plan may not rescind coverage except in cases of fraud or intentional misrepresentation of a material fact. This requirement is in addition to a plan's ability to cancel coverage for nonpayment of premiums, movement of the individual outside of a plan's service area and other established reasons.

- A rescission is a cancellation of coverage with a retroactive effect. A cancellation of coverage that is only prospective in nature is not a rescission. A retroactive cancellation for nonpayment of premiums is not a rescission.
- Coverage may not be rescinded unless notice is given at least 30 days in advance.
- An individual may appeal a decision to rescind coverage. Coverage must be continued until the appeals are final.

PATIENT PROTECTIONS – NON-GRANDFATHERED PLANS

There are three rules with respect to the choice of a health care professional for plans that have a network of providers. In addition, the plan or insurance carrier must comply with notice requirements advising participants of these rights.

- If designation of a primary care physician (PCP) is required, then all family members may designate their own individual PCP, provided that the PCP is a network provider and is available.
- A pediatrician may be selected as a PCP for children, provided that the PCP is a network provider and is available.
- No referral is required for obstetrical or gynecological care or services provided by an in-network specialist.

With respect to emergency services:

- Prior authorization requirements are prohibited regardless of whether care is provided in-network or out-of-network.
- No other limitations or other requirements are permitted that are more restrictive than those that apply to in-network services.
- Cost sharing must be the same as in-network emergency services.
- Out-of-network providers may balance-bill patients for the difference between the provider's charges and the amount collected from the plan. However, the regulations require that a reasonable amount be paid by the plan based upon a reasonable objective standard. Special rules are provided for HMOs with respect to the determination of reasonable objective standards.
- Anti-abuse rules provide that any other cost-sharing requirement, such as deductible or out-of-pocket maximums, may be imposed with respect to out-of-network emergency services only if the cost-sharing requirement generally applies to all out-of-network benefits. The goal of these rules is to prevent a plan or health insurance coverage from fashioning rules so that a participant is required to pay more for emergency services than for general out-of-network services.

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