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Health Care Reform Alert

IRS, DOL, & HHS Issue Interim Final Regulations on Annual and Lifetime Coverage Limits, Preexisting Condition Exclusions, Coverage Rescission, Emergency Coverage, and Provider Selection

On June 22, 2010, President Obama announced the release of the New Patient's Bill of Rights, which is actually the interim final regulations interpreting the health care reform law's (known as the Patient Protection and Affordable Care Act or "PPACA") limitations on annual and lifetime coverage limits, preexisting condition exclusions, coverage rescission, health care provider selection rules, and emergency coverage.

The regulations were published on June 28, 2010, and are available here. In addition, a White House fact sheet on the New Patient's Bill of Rights is available here.

The new regulations were released to clarify open points regarding the interpretation of gaps in the text of PPACA and in response to specific requirements imposed by PPACA on the Department of Health and Human Services ("HHS"), the Internal Revenue Service ("IRS"), and the Department of Labor ("DOL").

Preexisting Condition Exclusions
(Generally effective for plan years beginning on or after January 1, 2014; however, for participants under 19 years of age, effective for plan years beginning on or after September 23, 2010.)

The regulations amend the definition of a "preexisting condition exclusion" under the Health Insurance Portability and Accountability Act ("HIPAA") regulations to clarify that **a preexisting condition exclusion includes both a coverage exclusion for specific benefits associated with a particular preexisting condition as well as a complete exclusion from such plan or coverage based on the preexisting condition.**

The regulations do not address whether a preexisting condition exclusion may apply to a dependent following the date he or she turns 19 years of age. For example, if a grandfathered plan follows the HIPAA nondiscrimination rules for participants over 19 years of age and a participant is enrolled in the plan at 18 years and 9 months after having incurred a greater than 63-day gap between coverage, could the plan retroactively impose the pre-existing condition exclusion upon the child's attaining 19 years of age? We think the answer is probably not; hopefully future guidance will clarify this provision.

Annual and Lifetime Limits
(Lifetime dollar limits will be eliminated for plan years beginning on or after September 23, 2010; however, "restricted annual limits" may be imposed for plan years beginning prior to January 1, 2014.)

Annual and Lifetime Limits Do Not Apply to Flexible Spending Accounts ("FSAs"), Health Savings Accounts ("HSAs"), Medical Savings Accounts ("MSAs"), and Some Health Reimbursement Accounts ("HRAs")

Under PPACA, group health plans and health insurance issuers may not impose lifetime or annual limits on the dollar value of "essential health benefits." The regulations state that this provision does not apply to health FSAs. However, the regulations note that health FSAs are still subject to a $2,500 salary reduction contribution limitation for taxable years beginning after December 31, 2012. The regulations' preamble also exempts HSAs and MSAs, stating that these accounts are subject to annual contribution limitations and are generally not treated as group health plans because the funds can be used for medical and non-medical expenses.

The regulations do not completely exempt HRAs. The regulations' preamble divides HRAs into two categories: HRAs which are integrated with other coverage as part of a group health plan and stand-alone HRAs. The regulations' preamble states that **an HRA which is integrated with other coverage as part of a group health plan may retain the annual limit restriction without violating PPACA so long as the other coverage with which it is grouped satisfies the annual and lifetime limit restrictions**. For example, a high deductible health plan grouped with an HRA through which the employer reimburses its employees for the deductible appears to satisfy the "combined" relationship the Departments contemplated.

On the other hand, **it is unclear whether stand-alone HRAs will be subject to the limits**. The regulations state that a stand-alone HRA for retiree-only coverage will not be subject to the annual and lifetime limits, but the department declined to state whether the same exclusion applied to stand-alone HRAs which are not retiree-only plans. Instead, the Departments have requested comments on this issue.

Restricted Annual Limits on Essential Health Benefits

PPACA directs HHS to define "essential health benefit" and to establish restricted annual limits on essential health benefits for plan years beginning prior to January 1, 2014.

- **The regulations do not define essential health benefit**. Instead, for purposes of the restricted annual limit, HHS has stated that until it does issue such a definition, HHS, IRS, and DOL will take into account good faith efforts to comply with the "guidelines" set forth by PPACA. PPACA vaguely defines an essential health benefit to include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services.

The regulations provide the following guidance on good faith efforts:

> **EXAMPLE:** A plan would not satisfy a good faith standard if it applied a lifetime limit to a particular benefit (taking the position that it was not an essential health benefit) and, at the same time, treated that particular benefit as an essential health benefit for purposes of applying the restricted annual limit.

- Plans and issuers are permitted to gradually introduce the prohibition on annual limits to try to minimize the effect the removal of these limits may have on the cost of insurance coverage or to the plan. The regulations also establish the restricted annual limits on the dollar value of essential health benefits that plans must follow:

  - o $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;
  - o $1.25 Million for plan years beginning on or after September 23, 2011, but before September 23, 2012;
  - o $2 Million for plan years beginning on or after September 23, 2012, but before January 1, 2014.

  Note: the new restricted annual limits shown above are independent of the lifetime dollar limits which must be eliminated for plan years beginning on or after September 23, 2010 (no exception for grandfathered plans).

  The Secretary is also permitted to establish a "waiver program" for plans which may suffer a greater impact by changing their annual limits. The Secretary will release guidance on the waiver program at a future date. The regulations' preamble states that limited benefit plans, or "mini-med" plans, will be eligible for this waiver program.

  Caution: Grandfathered plans which have a higher annual limit than that established by the Secretary should not lower the limit to the HHS's thresholds. Doing so will cause the plan to lose grandfathered status.

Notices to Individuals Who Have Met Lifetime Limit

Action Item: Group health plans and issuers **must send notices to individuals who have lost coverage because they reached the lifetime limit**, provided the individual would otherwise be eligible for coverage on the first day of the first plan year beginning on or after September 23, 2010. The notice must state that the lifetime limit no longer applies and that the individual, if covered, is once again eligible for plan coverage.

If the individual is not enrolled in the plan, then the plan or issuer must give the individual a 30-day enrollment opportunity (and notice of the opportunity to enroll) no later than the first day of the first plan year beginning on or after September 23, 2010. This may be done as part of the open enrollment process. It is not clear whether the Departments will propose model language for this purpose.

Rescission of Coverage
(Effective for plan years beginning on or after September 23, 2010.)

Under PPACA, a group health plan is only permitted to rescind coverage in the event of fraud or intentional misrepresentation of a material fact and must provide notice of the rescission prior to its effective date. The regulations define a "rescission" as a cancellation or discontinuance taking retroactive effect, but exclude from the definition cancellations of coverage due to the failure to pay premiums. Thus, a plan that terminates coverage with prospective effect has not "rescinded" coverage.

The regulations also clarify that **when coverage is rescinded for fraud or intentional misrepresentation of a material fact, notice must be provided at least 30 calendar days prior to the date coverage is rescinded**.

Patient Protection
(Effective for plan years beginning on or after September 23, 2010.)

Selection of Health Care Provider (not applicable to grandfathered plans)

PPACA permits participants and beneficiaries of plans that require or allow the designation of a primary care provider to select available health care professionals for the provision of primary care (including pediatric care) and for obstetrical and gynecological ("OB-GYN") services.

Action Item: The regulations state that **when the plan requires the participant to designate a primary care provider, the plan must provide notice to each participant of the requirement with the SPD or similar description of benefits**. The regulations provide model language for this purpose (see below). Similar requirements apply for the designation of a pediatrician or OB-GYN.

In addition, a plan which provides coverage for OB-GYN care and requires designation of a primary care provider must inform each participant that the plan cannot require authorization or referral for OB-GYN care by a participating health care professional who specializes in OB-GYN. However, the plan may require that the professional agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the plan or issuer.

Model Language:
For plans and issuers that require or allow for the designation of primary care providers by participants and beneficiaries: "[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information]."

For plans and issuers that require or allow for the designation of a primary care provider for a child, add to the above: "For children, you may designate a pediatrician as the primary care provider."

For plans and issuers that provide coverage for OB-GYN care and require the designation by a participant or beneficiary of a primary care provider, add to the above: "You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics and gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

Emergency Services (not applicable to grandfathered plans)

Under PPACA, when a plan or health insurance coverage provides benefits for emergency services, it must do so without the individual or health care provider having to obtain prior authorization and without regard to whether the health care provider administering services is an in-network provider. Further, when the emergency services are provided out-of-network, the plan cannot impose an administrative requirement or coverage limit that is more restrictive than that imposed on in-network providers. Finally, when the emergency services are provided out-of-network, the plan must follow the regulation's cost sharing requirements, which will cause plans and issuers the most confusion.

- Cost-Sharing Arrangements

  There are two arrangements that require consideration: a cost sharing arrangement composed of a copayment and coinsurance requirement and a cost-sharing arrangement composed of other than a copayment and coinsurance requirement. We address these in reverse order.

  Any cost-sharing arrangement, other than a copayment or coinsurance requirement, may be imposed with respect to emergency services provided out-of-network as long as the cost-sharing arrangement generally applies to out-of-network benefits. The regulations offer the following example of a cost-sharing arrangement (other than a copayment or coinsurance) which satisfies the regulatory requirements:

  EXAMPLE: A group health plan generally imposes a $250 deductible for in-network health care. With respect to all health care provided by out-of-network providers, the plan imposes a $500 deductible. (Covered in-network claims are credited against the deductible.) The individual has incurred and submitted $260 of covered claims prior to receiving the emergency service out-of-network.

  The plan is not responsible for covering any claims with respect to the out-of-network emergency service until the covered individual satisfies the higher deductible that applies generally to all health care provided out-of-network**.**

When the cost-sharing arrangement is a copayment amount or coinsurance rate, the regulations have a different requirement. The amount or rate imposed on a participant for out-of-network coverage cannot exceed the requirement imposed for in-network coverage. However, because in-network providers usually negotiate a rate which may not exist with the out-of-network provider, there may be a coverage gap which the participant becomes required to pay. This coverage gap is also known as a "balance billing" amount. A balance billing situation arises where the participant is billed for the portion of the bill that the plan or insurer does not pay. This does not occur when the services are performed in-network because the provider has an agreement on the total cost of the service. Non-network providers do not have such an agreement, so they can balance bill. The following example illustrates a balance billing situation:

EXAMPLE: Assume Provider A is in-network and Provider B is out-of-network. An examination by Provider A has a negotiated rate of $120 with the plan. An examination of equal duration with Provider B costs $300. If the plan states that it covers both in-network and out-of-network exams at the level provided for in-network coverage, for example $120, then Provider B may look to the participant to recover the remaining $180.

The Departments concluded that even though PPACA does not prohibit balance billing, they believe it defeats the purposes of the PPACA protections to permit such an arrangement to exist. The regulations require that the plan or issuer engage in a determination of a different "reasonable" amount. For out-of-network emergency services, the Departments believe that a reasonable amount equals the greatest of:

- the amount negotiated with in-network providers for the emergency service furnished;
  - If there is more than one negotiated amount with in-network providers, the plan or issuer must use the median of all amounts negotiated with every in-network provider for the given emergency service. (Disregard this amount for purposes of determining the reasonable amount if there is no per-service amount negotiated with in-network providers.)

- the amount for the emergency service calculated using the same method the plan or issuer generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable charges), but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions; or
  - For purposes of determining this amount, the plan may not account for any out-of-network cost sharing that generally applies to out-of-network services.

- the amount that would be paid under Medicare for the emergency service.
  - This amount excludes any in-network copayment or coinsurance imposed on the participant or beneficiary.

The regulations provide the following example (modified):

> **EXAMPLE:** A group health plan covers individuals who receive emergency services with respect to an emergency medical condition from an out-of-network provider. The plan has agreements with several in-network providers with respect to a certain emergency service. Each provider has agreed to provide the service for a certain amount. Among all the providers for the service: one has agreed to accept $85, two have agreed to accept $100, two have agreed to accept $110, three have agreed to accept $120, and one has agreed to accept $150. Under the agreement, the plan agrees to pay the providers 80% of the agreed amount, with the individual receiving the service responsible for the remaining 20%.
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> The median amount among those agreed to for the emergency service is $110, and therefore, the amount the plan agreed to pay the in-service providers is $88 ($110 x 80%).
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> Assume that the out-of-network provider charges $125 for the service. With respect to services provided by out-of-network providers generally, the plan reimburses covered individuals 50% of the reasonable amount charged by the provider for medical services. For this purpose, the reasonable amount for any service is based on information on charges by all providers collected by a third party, on a zip-code by zip-code basis, with the plan treating charges at a specified percentile as reasonable. For the emergency service received by the individual, the reasonable amount calculated using this method is $116. The amount that would be paid under Medicare for the emergency service, excluding any copayment or coinsurance is $80.
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> The plan is responsible for paying $92.80 (80% x $116). Recall that the median amount was $110 and the amount the plan would pay is $88 (80% of $110); the amount calculated using the same method the plan uses to determine payments for out-of-network services - $116 - excluding the in-network 20% coinsurance, is $92.80; and the Medicare payment is $80. Therefore, the greatest amount is $92.80. The individual would remain responsible for the remaining $32.20 charged by the out of network provider.

***Caution**: Even where an employer uses a copayment or coinsurance arrangement for its out-of-service emergency service claims which is equal to the amount provided for in-service emergency service claims, there will be some issues administering these provisions. It will be important to discuss these issues with the insurance carrier or TPA.*

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