Health Care Reform Update: Interim Regulations Issued for "Patient's Bill of Rights" Requirements

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Many of the requirements in the Patient Protection and Affordable Care Act ("PPACA") will have little meaning until federal agencies issue regulations that clarify the statutory language. The Department of Health and Human Services, Department of Labor and Internal Revenue Service are all charged with issuing regulations to implement the Act. Since May, these agencies have issued a steady stream of interim regulations regarding a number of the Act's requirements. Most recently, on June 22, 2010, the agencies jointly issued interim regulations to implement what have been referred to as the "Patient's Bill of Rights" provisions of PPACA. The following provisions will take effect in plan years beginning on or after September 23, 2010.

Preexisting Condition Exclusions

PPACA prohibits a group health plan from imposing any preexisting condition exclusion ("PCE") on any individual under the age of 19. The age limit is eliminated for plan years beginning on or after January 1, 2014. In the interim, HIPAA's current PCE rules apply. The interim regulations accept the HIPAA definition of a preexisting condition as a health condition or illness that was present before an individual's effective date of coverage in the health plan, regardless of whether any medical advice was recommended or received before that date. A PCE is any limitation or exclusion of benefits (including a denial of coverage) that applies to an individual due to the individual's health status before the effective date of coverage under the health plan. A benefit limitation or exclusion is not a PCE, however, if it applies regardless of when the condition arose relative to the effective date of coverage.

Lifetime and Annual Dollar Limits on Essential Health Benefits

PPACA generally prohibits group health plans from imposing lifetime or annual limits on the dollar value of "essential health benefits," except that "restricted annual limits" on essential health benefits are allowed for plan years beginning before January 1, 2014. These rules do not prohibit a complete exclusion of benefits for any particular condition and are only applicable to essential health benefits. Group health plans may continue to impose lifetime and annual limitations on nonessential health benefits. The interim regulations define "essential health benefits" by cross-referencing the definition in the statute and the applicable (and hopefully soon to be issued) regulations. Until such regulations are issued, the agencies will take into account any good faith efforts to comply with a reasonable interpretation of the term.

With respect to plan years beginning prior to January 1, 2014, the interim regulations adopt a three-year phase-in for restricted annual limits on essential health benefits. The annual limit on any individual on the dollar amount of essential health benefits may not be less than:

- $750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011;
- $1.25 million for plan years beginning on or after September 23, 2011 but before September 23, 2012;
- $2 million for plan years beginning on or after September 23, 2012 but before September 23, 2013.

The interim regulations also include special rules relating to account-based plans such as FSAs, HSAs, HRAs and Archer MSAs. There is also a special transitional rule and written notice requirement with respect to any individual who lost coverage because he or she reached the lifetime limit on benefits whereby the individual must be advised that the lifetime limit no longer applies and that the individual (if still eligible) has a 30-day period in which to enroll.

Rescissions of Coverage

The new interim regulations clarify PPACA's prohibition against "rescissions" of health coverage. A rescission is defined in the regulations as "a cancellation or discontinuation of coverage that has a retroactive effect." Group health plans and health insurance issuers may not rescind coverage once an individual is covered by the plan unless "the individual makes an intentional misrepresentation of material fact, prohibited by the terms of the plan or coverage." This prohibition does not restrict plans from canceling coverage on a prospective basis. In addition, plans may terminate coverage retroactively to the extent termination is attributable to a failure to pay the required contribution toward the cost of coverage on a timely basis.

Choice of Health Care Professional

Any plan that requires participants or beneficiaries to designate a primary care provider ("PCP") may do so only if the participants or beneficiaries are given the option to "designate any participating primary care provider who is available to accept the participant or beneficiary." Plans must provide a written notice to each participant regarding the plan's terms governing designation of a PCP. The notice must be included in a summary plan description or similar document which explains the plan's benefits. The interim regulations provide model language that plans may use to satisfy this requirement.

Limits on Pre-Authorization

Under PPACA, plans may not require authorization or referral by the plan, health insurance issuer or any person (including a PCP) for a female participant or beneficiary to obtain coverage for obstetrical or gynecological care from an OB/GYN specialist; however, the specialist may be required to adhere to plan rules regarding "referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan…"

Similarly, the new interim regulations require that emergency services must be covered "without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis…" In addition, plans are prohibited from imposing any administrative requirement, limitation on coverage or cost-sharing requirement for out-of-network emergency services that would not otherwise apply if the services were rendered in-network. However, a participant may be required to pay the difference between an out-of-network provider's charges and the lower charge that would apply if the services were rendered in-network.

For additional information regarding health care reform, please click here to view the McNees Whitepaper regarding What Employers Need to Know about Health Care Reform. We will post additional articles on this blog as other regulations are issued.