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LEGAL ALERT

Legal Alert: More Health Care Reform Regulations Issued

7/21/2010

On June 28, 2010, the Departments of Health and Human Services, Labor and Treasury, published interim final regulations ("Interim Regulations") pertaining to the preexisting condition exclusions, lifetime and annual dollar limits, rescissions, choice of providers, and coverage of emergency services requirements under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (the "Act"). Most of the Interim Regulations are effective for plan years beginning on or after September 23, 2010, which means an effective date of January 1, 2011 for calendar year plans. The prohibition of preexisting condition exclusions for individuals under the age of 19, has the above effective date, but that prohibition is not applicable to all other individuals until January 1, 2014. With the exception of the patient protections (choice of providers and coverage of emergency services requirements), the Interim Regulations apply to *both* grandfathered and non-grandfathered group health plans.

Preexisting Condition Exclusions

The Act precludes group health plans from imposing a preexisting condition exclusion on individuals under the age of 19 (beginning on September 23, 2010) and on all individuals (beginning on January 1, 2014). "Preexisting condition exclusion" is defined in the Interim Regulation as a limitation or exclusion of benefits or a denial of coverage based on the fact that the condition was present before the effective date of coverage "or if coverage is denied, the date of denial." It does not matter whether any medical advice, diagnosis, care, or treatment was recommended or received before that date. The definition includes any limitation or exclusion that is based on information relating to an individual's health status, "such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period." However, a limitation or exclusion of benefits is not considered a prohibited preexisting condition exclusion if it applies regardless of when the condition arose relative to the effective date of coverage.

Annual and Lifetime Dollar Limits on Essential Health Benefits

The Act precludes the imposition of annual or lifetime dollar limits on "essential health benefits." However, prior to January 1, 2014, "restricted annual limits" on essential health benefits are permitted.

The Act identifies the categories of "essential health benefits" as:

• 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, including oral and vision care.

The Interim Regulations do not provide any further guidance as to what constitutes "essential health benefits." Further, the Interim Regulations do not address whether visit or day limits or per procedure dollar limits are permissible, although complete exclusion of benefits for a particular condition is permissible. The Interim Regulations do provide that the agencies will take into account "good faith efforts" to comply with a "reasonable interpretation" of the term "essential health benefits" until a definition is provided, but for an interpretation to be reasonable, it must be applied consistently with respect to annual and lifetime limits.

Neither the Act nor the Interim Regulations precludes the imposition of annual and lifetime limits on non-essential health benefits.

Restricted Annual Limits

As noted above, restricted annual limits are permissible with respect to "essential health benefits" until January 1, 2014. The Interim Regulations provide for a "three-year phased approach" in applying annual limits until January 1, 2014. A group health plan may impose annual limits on the dollar amount of "essential health benefits," provided the limit for each covered individual is not less than:

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

• $1,250,000 for plan years beginning on or after September 23, 2011, but before September 23, 2012; and

• $2,000,000 for plan years beginning on or after September 23, 2012, but before September 23, 2013.

Group health plans with annual limits exceeding these amounts may reduce their limits to comply with the above limits. However, such changes could affect the grandfathered status of the plan.

The Interim Regulations specifically exempt Health Flexible Spending

Accounts, Medical Savings Accounts, Health Savings Accounts, and retiree-only Health Reimbursement Accounts from complying with the annual and lifetime limit requirements. Health Reimbursement Arrangements, which are "integrated with other coverage" as part of a group health plan, do not violate the limit requirements if the other coverage alone complies with the annual and lifetime limit requirements.

Re-enrollment Period After Lifetime Maximum Reached

For those individuals who previously reached a lifetime maximum, the Interim Regulations require that the group health plan provide the individual with a one-time opportunity to enroll for coverage again under the plan, if they are not covered. The group health plan must provide written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual is once again eligible to enroll in the plan, if not enrolled, and eligible for benefits under the plan. The re-enrollment period must be at least 30 days. The notice and the re-enrollment period must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010, and re-enrollment and eligibility for benefits must take effect not later than the first day of that plan year. An individual who is eligible to re-enroll in the group health plan under this procedure is treated as a HIPAA special enrollee and is eligible to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

Model Notice

The notice may be provided to an employee on behalf of the employee's dependent(s). Alternatively, the notice may be included with other enrollment materials that a group health plan distributes to employees, provided that the statement regarding eligibility is prominently displayed.

The Interim Regulations contain model language. Additionally, the Department of Labor has issued a model notice that may be used for individuals who previously reached a lifetime maximum, which is available at: http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc.

Waiver from Compliance with Annual Limits

A waiver from compliance with annual limits may become available. The Interim Regulations state that before January 1, 2014, the Secretary for the Department of Health and Human Services ("HHS") may establish a program under which a waiver may be provided to group health plans with non-compliant annual limits if compliance with the annual limit requirements "would result in a significant decrease in access to benefits under the plan or would significantly increase premiums for the plan." If established, the waiver program would allow individuals with limited benefit or "mini-med" plans to continue to receive coverage under those plans, so that they would not be denied access to benefits or experience more than a minimal impact on premiums.

Prohibition on Rescissions

The Act prohibits a group health plan or insurance carrier from rescinding coverage of an individual unless the individual has performed an act or omission, or engaged in a practice that constitutes fraud, or has made an intentional misrepresentation of a material fact. Rescission is defined in the

Interim Regulations as a retroactive cancellation or discontinuance of coverage. The Interim Regulations explain that a rescission would include a cancellation that renders the coverage void from the time of the individual or group's enrollment or that voids benefits for up to a year before cancellation. However, a cancellation will not be considered a rescission if it is prospective only or if it is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward cost of coverage.

Advance Notice of Rescission Required

The Interim Regulations provide that the group health plan must provide at least 30 days advance written notice to each individual affected before coverage is rescinded. The notice must be provided regardless of whether the rescission applies to the entire group or only an individual within the group. The purpose of the advance written notice is to provide the plan sponsor or individuals losing coverage "the opportunity to explore their rights to contest the rescission or look for alternative coverage."

Patient Protections

The Act contains two sets of patient protection requirements: (1) choice of health care providers and (2) emergency services benefits. These apply to non-grandfathered group health plans only.

Choice of Health Care Providers

The Interim Regulations confirm that the choice of health care provider requirement applies when a group health plan uses a network of providers. It does not apply when a group health plan (or insurance carrier) has not negotiated with any provider for the delivery of care, but only reimburses the cost of services pursuant to the terms of the group health plan.

If a group health plan requires a participant or beneficiary to designate a primary care provider, the group health plan must permit each individual to designate "any participating primary care provider who is available to accept" the individual. A default primary care provider can be designated by the group heath plan until the individual makes an affirmative designation.

If a group health plan requires the designation of a primary care provider for a child, the group health plan must permit the designation of a pediatrician if that pediatrician is a member of the network of providers and is available to accept the child.

If a group health plan provides coverage for obstetric and gynecological (OB/GYN) care and requires the designation of a primary care provider, the group health plan cannot require an individual to seek a referral from her primary care provider or to obtain prior authorization in order to seek treatment from a health care provider specializing in OB/GYN services. However, the group health plan can require the OB/GYN provider to comply with terms of the plan, such as obtaining authorization for certain procedures. In addition, the group health plan can require the OB/GYN provider to keep the primary care provider informed concerning the individual's course of treatment.

Model Notice for Choice of Health Care Providers

If the group health plan requires the designation of a primary care provider, written notice must be provide to each participant of the plan of the designation requirement and of their right to choose health care providers within the network. The notice must be included with the summary plan description or other similar description of benefits under the group health plan or insurance coverage.

The Department of Labor has issued a model notice for informing individuals of their rights regarding choice of a health care provider, which is available at: http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc

Emergency Services

The Act requires that if a group health plan provides benefits for emergency services, those benefits must be provided without prior authorization and irrespective of whether the service was provided in or out of network. The Interim Regulations state that if a group health plan provides any benefits for services in a hospital's emergency department for an "emergency medical condition," the group health plan must provide coverage for emergency services as follows:

• without the need for prior authorization, whether in or out of network (the plan may impose a notice requirement);

• without regard to whether the emergency service is provided by a participating network provider;

• without imposing any limitation or administrative requirement that is more restrictive for out-of-network services than for in-network services;

• without regard to any other term or condition of the plan other than benefit exclusions, coordination of benefits, a permitted affiliation or waiting period, or applicable cost-sharing requirements; and

• without imposing greater copayments or coinsurance rates on emergency services provided by an out-of-network hospital than applies for services provided by an in-network hospital.

However, for purposes of requirement 5, the Interim Regulations provide that a group health plan satisfies the copayment and coinsurance limits if it provides benefits for out-of-network emergency services in an amount equal to the greatest of the following three amounts:

• the median amount negotiated with in-network providers for emergency services;

• the amount calculated using the same method the group health plan generally uses to determine payments for out-of-network services, such as "usual, customary, and reasonable"; and

• the amount that would be paid under Medicare.

The Interim Regulations do not preclude out-of-network providers from balance billing the individual for the costs not reimbursed by the group health plan.

The above requirements do not preclude a group health plan from imposing a deductible or out-of-pocket maximum with respect to out-of-network coverage if those same cost-sharing requirements are applied to all out-of-network benefits.

The above requirements do not apply to treatment of non-emergency medical conditions or to treatment provided in locations other than a hospital's emergency department.

Employers' Bottom Line:

Employers (plan sponsors) should consider whether their plans are grandfathered group health plans or not. Based on that status, employers should consider what changes have to be made to their group health plans in order to comply with the above requirements. If changes have to be made, plans should be amended accordingly and participants notified through a revised summary plan description or a summary of material modifications. Also, required notices should be provided to individuals, *e.g.,* regarding the right to choose health care providers if the plan requires a designation of a primary care provider. Finally, employers should review their records in order to determine if any individuals may have reached lifetime maximum limitations and provide the required notice to those individuals of their opportunity to re-enroll in the plan and/or their eligibility for benefits under the plan.

If you have any questions regarding this Alert, or would like additional details concerning health care reform, you can contact the author of this Alert, Tiffany D. Downs, 404-888-3961, tdowns@fordharrison.com, any member of Ford & Harrison's Employee Benefits practice group or the Ford & Harrison attorney with whom you usually work.

You may also visit the health care reform tab of the Ford & Harrison website, http://www.fordharrison.com/HealthcareReform.aspx, for more helpful resources and tools on health care reform.