Client Advisory

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Employee Benefits and Executive Compensation

July 19, 2010

New Regulations Issued Regarding Patient's Bill of Rights

On June 22, the Departments of Health and Human Services, Labor and Treasury jointly issued interim final regulations implementing the "Patient's Bill of Rights" requirements of the Patient Protection and Affordable Care Act of 2010 (PPACA). The rules regarding lifetime and annual dollar limits, preexisting condition exclusions and coverage rescissions generally apply to all group health plans for plan years starting on or after September 23, 2010, including "grandfathered" plans. The patient protection provisions, however, do NOT apply to grandfathered plans.

Prohibition on Lifetime and Annual Limits. PPACA prohibits plans from imposing annual limits or lifetime limits on the dollar amount of "essential health benefits." Essential health benefits, according to PPACA, include at least the following categories: emergency services; hospitalization; maternity and newborn care; mental health and substance abuse; prescription drugs; rehab services and devices; lab services; preventive and wellness services; chronic disease management; pediatric services; and ambulatory patient services. The regulations do not provide guidance regarding what is or is not considered an essential health benefit, but permit good faith efforts to comply with a reasonable interpretation of that term. Note that these essential health benefits are not required to be provided by employer plans. However, if such benefits are provided by an employer plan, lifetime and annual limits cannot be imposed in violation of the new regulations.

Additional notice and enrollment rules apply with respect to participants or beneficiaries whose coverage or benefits ended by reason of having reached a lifetime limit. For example, individuals who have reached the plan's lifetime limit prior to the effective date of the new regulations must be notified that the lifetime limit no longer applies, and those who are not enrolled in the plan must be given an opportunity to do so.

The prohibition against annual limits will be phased in until 2014. The dollar value of essential health benefits must be no less than $750,000 for plan years beginning on or after September 23, 2010; no less than $1.25 million for plan years beginning on or after September 23, 2011; and no less than $2 million for plan years beginning on or after September 23, 2012 (and before January 1, 2014). The regulations allow plans with an annual dollar limit on benefits below the permitted levels, to seek a waiver to delay compliance with the regulations if the plan can prove that compliance would result in a significant decrease in access to benefits or a significant increase in premiums. Examples of such plans would be limited benefit plans, which without such waivers, employers might drop entirely rather than increase the lifetime or annual limits to comply with the regulations.

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The restrictions on annual limits do not apply to flexible spending accounts, medical savings accounts, health reimbursement arrangements (HRAs) if the HRA is integrated with coverage under a group health plan, or stand-alone retiree HRAs.

Though the regulations do not specify whether a plan may impose annual and lifetime limits on the number of days/visits (in contrast with dollar limits), non-monetary limitations appear to be permissible (except for mental health and substance use disorder benefits).

Prohibition on Preexisting Condition Exclusions. The Health Insurance Portability and Accountability Act already limits plans' ability to impose preexisting condition exclusions and requires that exclusionary periods be offset by creditable coverage from other plans. PPACA prohibits plans from imposing any preexisting condition exclusion on enrollees under age 19. Plans may continue to apply preexisting condition exclusions currently in effect with regard to enrollees age 19 and older until the 2014 plan year. The regulations clarify that these prohibitions apply for purposes of denying enrollment in the plan and for specific benefit coverage.

Prohibition on Coverage Rescission. PPACA prohibits plans from retroactively rescinding coverage unless due to fraud or intentional misrepresentation. The regulations provide guidance as to what constitutes rescission and when it is permitted. According to the regulations, rescission is permitted to retroactively terminate coverage for failure to pay premiums in a timely manner. A termination with only a prospective effect, such as if ineligible dependents are to be dropped pursuant to an audit of dependent coverage, is not considered a rescission and thus is also permitted.

New Patient Protection Rules (Applicable to Non-Grandfathered Plans Only). If a plan utilizes a network of providers, there are three new choice-of-provider requirements imposed by PPACA: (1) the plan must allow participants to designate any participating primary care provider (PCP) who is available; (2) the plan must allow a participating pediatrician to be designated as the PCP for a child; and (3) the plan cannot require any preauthorization or referral to access an OB/GYN. The regulations require plans to notify participants of these rights and provide model language for this purpose. Note that the recent release of model language by Department of Labor includes a requirement that this notice must be distributed no later than the first plan year after September 23, 2010. Thus, if summary plan descriptions are not going to be distributed at this time, plan sponsors should consider incorporating the model language into open enrollment materials for non-grandfathered plans.

New requirements also are provided in the regulations with regard to emergency services, including prohibiting prior approval for emergency care, whether in-network or out-of-network, and outlawing out-of-network co-pays or coinsurance requirements that exceed in-network levels (though out-of-network deductibles may be imposed if they generally apply to all out-of-network benefits).

Action Required Now. Though not all questions raised by PPACA have been answered, there has been enough guidance issued via regulations such that plan sponsors should be in the process of identifying required changes to existing plans for the upcoming open enrollment. Decisions will need to be made as to what changes are required and as of what date, whether grandfather status will be lost if additional changes are made, what documents need to be revised, and how participants will be notified of changes.

Click here to view the interim final regulations.