ROPES & GRAY

Federal Agencies Issue Interim Final Rules for the Patient's Bill of Rights

The U.S. Departments of Treasury, Labor, and Health and Human Services have issued interim final rules for group health plans and health insurance coverage on certain patient protections under the *Patient Protection and Affordable Care Act.* These rules, commonly referred to as the Patient's Bill of Rights, provide important guidance for employers and insurers as they work to ensure that their health plans and benefits are compliant for upcoming plan years.

Lifetime and Annual Limits

Under the Act, both self-insured and fully-insured health plans are prohibited from: (1) imposing lifetime limits on “essential health benefits” for plan years beginning on or after September 23, 2010, (2) imposing annual limits on essential health benefits, other than “restricted annual limits,” for plan years beginning prior to January 1, 2014, and (3) imposing any annual limits on essential health benefits for plan years beginning on or after January 1, 2014. The rules clarify that lifetime and annual limits may still be imposed on specific covered benefits which are not essential health benefits (to the extent otherwise permitted by Federal and State law). Also, a group health plan or a health insurer offering group health insurance coverage may continue to exclude all coverage for a specific condition (so long as such exclusion complies with other requirements of Federal or State law) without violating the Act, but if any benefits are provided for a condition, the rules governing lifetime and annual limits apply. Importantly, the term "essential health benefits" has yet to be further defined. Until it is, employers will have to reasonably rely on the description of benefits provided in Section 1302 of the Act.

Restricted annual limits are defined as a schedule of minimum dollar thresholds that are applied to essential health benefits. For plan years beginning on or after September 23, 2010, but before September 23, 2011, the restricted annual limit threshold is $750,000 per individual. This threshold increases to $1,250,000 per individual for years beginning on or after September 23, 2011, and to $2,000,000 for plan years beginning on or after September 23, 2012. No restricted annual limit may be imposed for plan years beginning on or after January 1, 2014. These limits apply on an individual-by-individual basis, so any limits applied to families under a plan may not operate to deny an individual participant the minimum annual benefits to which he or she is entitled. The rules also provide that the Secretary of HHS may establish a program under which waivers of these thresholds may be granted where the imposition of the threshold would “result in a significant decrease in access to benefits. . . or would significantly increase premiums.” The cost of non-essential health benefits provided to an individual is not included in determining whether that individual has met the restricted annual limit for a given year.

Transitional rules are also provided for individuals who lost prior coverage due to reaching a lifetime limit. Any individual who (1) lost coverage under a group health plan (or a coverage option under the plan) when he or she reached the plan's lifetime limit and (2) would be eligible for benefits not subject to lifetime limits, must be permitted to re-enroll in the group health plan on the same basis as a newly eligible participant, and must be given the option of participating in any coverage provided under the plan. This re-enrollment right is available even if the individual enrolled in a different coverage option under the group health plan after reaching the lifetime limit under his or her prior coverage. Any individual who becomes eligible to enroll or re-enroll in

coverage under this rule must be provided with a notice, delivered on or before the first day of the plan year beginning on or after September 23, 2010, explaining their enrollment rights, and must have at least 30 days to exercise those rights. If this notice is included with other enrollment materials, then the notice of availability of coverage must be "prominent." This notice requirement may be satisfied with respect to an employee's dependents by providing notice to the employee. If the individual elects to enroll in the health plan or a specific coverage under the plan, such enrollment will be effective as of the first day of the plan year.

The rules also explain that annual limits do not apply to health flexible spending account plans, Archer MSAs or health savings accounts. Also, if an employer offers a health reimbursement arrangement that is integrated with other coverage as part of a group health plan and the other coverage alone would comply with the Act, the fact that benefits under the HRA by itself are limited will not violate the Act. Finally, a stand-alone HRA that is available only to retirees is generally not subject to the Act and these rules.

The rules on lifetime limits apply to all plans regardless of their grandfathered status. The annual limit rules apply to plans that lose their grandfathered status and to grandfathered group health plans and group health insurance coverage. Recall, however, that any decrease in the annual limit from the level that existed on March 23, 2010 or any addition of a new annual limit (other than an annual limit that replaces a lifetime dollar limit that is at least as high as that lifetime limit) will result in the loss of grandfathered status. For further information on grandfathered plans, see Ropes & Gray's Alert.

Prohibition of Preexisting Condition Exclusions

Under the Act, a group health plan or health insurer offering group health insurance coverage may not impose any preexisting condition exclusions on any participant for plan years beginning on or after January 1, 2014 and, for children under the age of 19, for plan years beginning on or after September 23, 2010. The rules define a "preexisting condition exclusion" as a limitation or exclusion of benefits based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was received before that date. The rules make clear that plans and insurers cannot deny participants coverage of specific benefits associated with a preexisting condition or exclude an individual from the plan or coverage altogether based on a preexisting condition.

The prohibition on preexisting condition exclusions applies to plans regardless of their grandfathered status.

Patient Protections

The Act loosens any restrictions imposed on the choice of certain health care providers and on access to emergency services. The rules state that a plan or issuer that requires or provides for participant designation of a primary care physician must permit each participant to select any available participating primary care provider who is part of the plan's network. Similarly, a plan or issuer that requires or provides for designation of a primary care physician for a child must permit the participant to designate any available pediatrician who practices in the plan network. Finally, a female participant who seeks coverage for obstetrical or gynecological care may not be required by the plan or issuer to obtain authorization or a referral for care provided by a participating health care professional who specializes in obstetrics and gynecology. The plan or issuer must provide a notice to accompany any summary plan description, or other description of benefits, informing the participant of the plan terms regarding designation of a primary care provider and their rights to choose the applicable health care professional. Model language for this notice is provided in the rules.

The rules also require any plan or issuer that provides emergency services to do so (1) without requiring prior authorization, even when the services are provided out-of-network, (2) without regard to whether the particular health care provider is a participating network provider with respect to the services, (3) without imposing any administrative requirement or limitation on coverage for out-of-network services that is more restrictive than that which applies to in-network services, and (4) by complying with cost-sharing requirements for out-of-network services.

Plans cannot impose copayments or coinsurance requirements on out-of-network emergency services that are greater than those imposed on in-network emergency services. Insurers may, however, require participants to pay amounts in excess of the amount an out-of-network provider charges over the amount the plan would have paid for in-network care. Finally, any cost-sharing requirement other than a copayment or coinsurance (*e.g.*, a deductible or out-of-pocket maximum) may be imposed on out-of-network emergency services if such requirement generally applies to out-of-network benefits. In this case, the deductible may be imposed only as part of a deductible that generally applies to out-of-network benefits and any out-of-pocket maximum that is imposed must apply to out-of-network emergency services.

These patient protection provisions apply for plan years beginning on or after September 23, 2010. Grandfathered plans do not need to comply with these rules.

Rescission

The Act provides that a group health plan or insurer may not rescind coverage under a health plan for plan years beginning on or after September 23, 2010, unless the rescission is due to an individual's act that constitutes fraud or an intentional misrepresentation of a material fact. The rules clarify that a rescission is any cancellation or discontinuance of coverage with a retroactive effect, however, coverage may be withdrawn retroactively to the extent that it is attributable to the participant’s failure to pay premiums or contribution amounts in a timely manner. Under the rules, rescissions are only permitted to the extent that the individual's actions leading to the rescission are prohibited by the terms of the plan. The rules also expressly allow any cancellation of coverage which has only a prospective effect. Notice must be given in writing at least 30 days in advance of any rescission of coverage. Although the rules do not define fraud or intentional misrepresentation of material facts, examples illustrate that an inadvertent omission of information on a medical history questionnaire or a mistake made by the plan or insurer do not meet the criteria for rescinding coverage.

The prohibition on rescission applies to plans regardless of their grandfathered status.

The rules are effective 60 days from the date they are published in the Federal Register and comments will be accepted during this period. Further changes to the Patient's Bill of Rights may be made after the comments have been reviewed.

If you have any questions about the rules and how they apply to your plans, please contact your usual Ropes & Gray advisor or any member of our Employee Benefits practice or Benefits Consulting Group. You should also refer to the Ropes & Gray Health Reform Resource Center for copies of the rules and related guidance.