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JULY 2010

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Highlights of the New "Patient's Bill of Rights" Regulations Implementing Key Features of Federal Health Reform

On June 22, 2010, the Departments of Health and Human Services, Labor, and Treasury issued joint interim final regulations addressing some of the consumer protection provisions of the Patient Protection and Affordable Care Act (PPACA). Labeled a "Patient's Bill of Rights," these regulations implement five key features of PPACA:

- **The elimination of pre-existing condition exclusions.** Group health plans and insurance companies will no longer be allowed to impose any pre-existing condition exclusions on individuals under the age of 19, effective for plan years beginning on or after September 23, 2010 (which means January 1, 2011 for calendar year plans). As of January 1, 2014, pre-existing condition exclusions must be eliminated for ***all*** individuals, regardless of age. The restrictions on pre-existing condition exclusions apply to both grandfathered and non-grandfathered plans.

- **The elimination of most rescissions of health coverage.** A rescission occurs when a group health plan or insurance company retroactively cancels health coverage. Previously, plans or insurance companies could rescind coverage based on a relatively minor paperwork mistake, if permitted under the terms of the plan. However, under the new regulations, group health plans and insurance companies will only be allowed to rescind coverage in cases of fraud or intentional misrepresentations of material facts. If a group health plan or insurer intends to rescind coverage for one of these permissible reasons, it must provide the individual with 30 days' notice before doing so (although the rescission can still be effective retroactively). The restrictions on rescissions apply to both grandfathered and non-grandfathered plans, effective for plan years beginning on or after September 23, 2010.

- **The elimination of lifetime dollar limitations on "essential health benefits."** The regulations prohibit group health plans and insurance companies from imposing lifetime limits on the total amounts paid for "essential health benefits" (although "non-essential health benefits" may still have lifetime limitations). Regulations have not yet been issued outlining the difference between an "essential" and a "non-essential" health benefit—a distinction that will become important as plan sponsors redesign their plans. For the moment, plan sponsors must rely on statutory language in PPACA, which defines "essential health benefits" to include items such as ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitation services, lab services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care.

  As a result of this change, any individual who has previously reached a plan's lifetime dollar limitation on benefits, but who now is eligible to participate due to the elimination of those lifetime limits, must be offered a 30-day special enrollment period so that he or she can re-enroll under the plan. This special enrollment requirement should be of particular interest to employers who are planning their open enrollment seasons for 2011, because the notice of the special enrollment period can be included with other open enrollment materials. To help employers notify affected individuals about their special enrollment rights (through open enrollment materials or otherwise), the Department of Labor has published a model notice, which can be found here. The prohibition on lifetime limits applies to both grandfathered and non-grandfathered plans, effective for plan years beginning on or after September 23, 2010.

- **The gradual elimination of annual dollar limitations on "essential health benefits."** While *lifetime* limitations on essential health benefits will be impermissible for plan years beginning on or after September 23, 2010, group health plans and insurers will still be able to impose some *annual* limitations on "essential health benefits" until 2014. The regulations adopt a 3-year phased approach, restricting such annual limits for each individual under the plan to:

  - $750,000 for plan/policy years beginning on or after September 23, 2010 and before September 23, 2011;

  - $1.25 million for plan/policy years beginning on or after September 23, 2011 and before September 23, 2012; and

- $2 million for plan/policy years beginning on or after September 23, 2012 and before January 1, 2014.

For plan/policy years beginning on or after January 1, 2014, no annual dollar limitations for essential health benefits will be permitted. The restrictions on annual dollar limits apply to both grandfathered and non-grandfathered plans.

- **The protection of an individual's choice of health care provider.** PPACA also provides that non-grandfathered group health plans and insurance policies must allow plan participants to designate any available participating primary care provider as their primary care provider. This includes allowing parents to choose any available participating pediatrician as their child's primary care provider. Further, group health plans and insurers may not require authorization or a referral for a female patient to see a health care professional that specializes in obstetrics or gynecology.

  Plans or policies that require participants to designate primary care providers or pediatricians must provide individuals with 30 days' notice about any plan terms requiring the individual to designate a primary care provider (or pediatrician) and about providing access to obstetrical and gynecological services. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. To help employers meet this notice requirement (which can be incorporated into open enrollment materials), the Department of Labor has issued a model notice, which can be found here. These provisions apply only to non-grandfathered plans; grandfathered plans are exempt from these requirements.

- **The removal of network restrictions and cost-sharing limitations for emergency room services.** Effective for plan years beginning on or after September 23, 2010, non-grandfathered group health plans and insurers will not be able to charge additional copayments or coinsurance for emergency services provided outside of the plan's network. The new regulations include detailed provisions about how these cost-sharing provisions will work. Generally, out-of-network emergency services cannot be any more expensive for the individual than in-network emergency services. These provisions apply only to non-grandfathered plans; grandfathered plans are exempt from these requirements.

The Patient's Bill of Rights regulations are the latest wave of guidance from the government implementing PPACA, joining other recently-issued regulations about what plans can (and cannot) do if they wish to retain their status as a "grandfathered plan" that is exempt from many of PPACA's requirements. In addition, the Department of Labor has issued a model notice that plans can use to notify individuals about new 30-day special enrollment rights that are available to provide coverage to adult children under age 26, which can be found here. This rule also takes effect for plan years beginning on or after September 23, 2010 (with certain limitations available only to grandfathered plans); consequently, this model notice can also be incorporated into any open enrollment materials that are being prepared for the 2011 plan year.

We would be happy to answer any questions that you may have regarding the Patient Protection and Affordable Care Act, its effect on your plans, or any other employee benefit programs.

Please contact any of the attorneys in our Employee Benefits & Executive Compensation group if you have any questions regarding this alert.

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