CONNER STRONG

Legislative Update

June 24, 2010

Patient's Bill of Rights Regulations Released

On June 22, agencies of the federal government released interim final regulations setting forth the requirements for group health plans regarding pre-existing condition exclusions, lifetime and annual limits, coverage rescissions, and patient protections. The regulations, referred to as "Patient's Bill of Rights" regulations in a White House fact sheet, apply to plan years starting on or after September 23, 2010. For calendar year group health plans, these requirements apply January 1, 2011.

These regulations are important as they spell out the "rules of the road" for some of the new provisions of national health insurance reform that take effect soon. For employers and plan sponsors, these regulations outline how changes will need to be handled in order to comply with the new law. The interim final regulations address the following provisions that generally apply to all health plans, including grandfathered health plans:

- ***Pre-existing Condition Exclusions*:** Plans are prohibited from imposing preexisting condition exclusions for both benefit limitations and coverage, effective for plan years beginning on or after January 1, 2014. But for individuals under age 19 they become effective for plan years on or after September 23, 2010.

- ***Lifetime Limits:*** Prohibits lifetime limits on the dollar value of "essential health benefits." A plan may impose lifetime per-individual dollar limits on covered benefits that are not essential health benefits. Additional notice and enrollment opportunity rules apply for individuals whose coverage or benefits ended by reason of reaching a lifetime limit.

- ***Annual Dollar Limits:*** Prohibits annual limits on the dollar value of benefits generally, but allows "restricted annual limits" with respect to "essential health benefits" up to 2014 (for plans renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits are prohibited.).

A three-year phased approach applies for restricted annual limits for "essential health benefits:"

- $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, 2014.

A plan may impose annual per-individual dollar limits on covered benefits that are not essential health benefits. Good faith compliance with a "reasonable interpretation" of what is an "essential health benefit" will be allowed until regulations defining that term are issued.

- The restriction on annual limits does not apply to health flexible spending arrangements (FSAs), medical savings accounts (MSAs), or health savings accounts (HSAs), and the annual limit restriction does not apply to health reimbursement arrangements (HRAs) that are integrated with other coverage as part of a group health plan that otherwise complies with lifetime and annual dollar limits. Retiree-only HRAs are also not subject to the annual limits. Guidance is expected on the application of the annual limits to stand-alone HRAs.

- The minimum annual limits for plan years beginning before 2014 apply on an individual-by-individual basis, meaning that any overall annual dollar limit for families may not operate to deny a covered individual the minimum annual benefits for the plan year.

- A notice and special enrollment opportunity must be offered for individuals who are not eligible for benefits because of the prior application of an annual and lifetime limits rule.

- Group health plans that have an annual dollar limit on benefits below the restricted annual limits permitted, such as limited benefit plans, may seek a waiver to delay compliance with the rules on restricted annual limits if the plan can prove that its current annual limits are necessary to prevent a significant loss of coverage or increase in premiums. Guidance regarding the scope and process for applying for a waiver is expected to be issued in the near future.

- ***Retroactive Rescissions:*** Prohibits retroactive rescissions of coverage except in cases of fraud or an intentional misrepresentation of material facts, with no exception. A cancellation or discontinuance of coverage with only a prospective effect is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Plans are required to provide at least 30 days advance notice of a rescission with time to appeal.

The following consumer protections apply to non-grandfathered plans with a network of providers:

- Prohibiting group health plans from requiring a referral for OB-GYN care or from allowing a pediatrician to be a designated primary care provider.

- Prohibiting prior approval for emergency care or higher cost-sharing amounts for out-of-network emergency care.

- Requiring a "reasonable" reimbursement for providers of out-of-network emergency care before balance billing is allowed.

As new information is issued on health reform, Conner Strong will issue alerts and updates. **Should you have any questions, please contact your Conner Strong representative toll-free at 1-877-861-3220.**