

Departments Issue Core Interim Regulations Under PPACA

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On June 22, 2010, the U.S. Departments of Treasury, Labor and Health and Human Services jointly issued another set of interim final regulations (“Interim Regulations”), this time implementing the provisions of the Patient Protection and Affordable Care Act (PPACA) on preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions and patient protections. For group health plans and group health insurance coverage, the Interim Regulations are effective for plan years beginning on or after September 23, 2010 (except for preexisting condition exclusion limitations for individuals 19 or older, which apply for plan years beginning on or after January 1, 2014). The regulations reiterate that the requirements relating to preexisting condition exclusions, lifetime and annual limits, and rescissions apply to grandfathered group health plans (in certain cases, compliance is not required by grandfathered health plans that are individual health insurance coverage). The rules relating to patient protections, however, do not apply to grandfathered health plans. While the Interim Regulations also address individual health insurance coverage, this advisory is limited to the rules as they apply to group health plans and group health insurance coverage. For convenience, the term “group health plans” is used in this advisory to refer to both group health plans and group health insurance coverages. Comments on the Interim Regulations are due 60 days after publication in the Federal Register (June 28, 2010).

Practice Pointer: As with all of the health insurance reforms that were added to Title 27 of the PHSA, these rules do not apply to “excepted” benefits as defined in PHSA 2791(c).

NOTE: The DOL has recently provided helpful links to the following:

Regulations

<http://www.dol.gov/federalregister/HtmlDisplay.aspx?DocId=23983&AgencyId=8&DocumentType=2>

Fact Sheet

http://www.healthreform.gov/newsroom/new_patients_bill_of_rights.html

Lifetime limits model notice

<http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc>

Patient protection model notice

<http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc>

They have even provided a model enrollment notice for adult children under age 26, which you can find at <http://www.dol.gov/ebsa/dependentsmodelnotice.doc>.

Prohibition on Preexisting Condition Exclusions

PPACA prohibits group health plans from denying coverage based on an applicant's preexisting condition. Essentially adopting the existing HIPAA definition, the Interim Regulations define preexisting condition exclusion as a benefit limitation or exclusion or denial of coverage based on the fact that the condition was present before the effective date of group health plan coverage (or if coverage is denied, the date of the denial), whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date.

It includes benefit limitations or exclusions as a result of health conditions identified through a pre-enrollment questionnaire or physical examination, or review of medical records relating to the pre-enrollment period.

A benefit limitation or exclusion is not a preexisting condition exclusion, however, if it applies regardless of when the condition arose relative to the effective date of coverage.

The prohibition on preexisting exclusions is effective for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans), with respect to individuals who are under age 19. For all other individuals, the prohibition on preexisting condition exclusions is effective for plan years beginning on or after January 1, 2014. In the interim, HIPAA's current preexisting condition exclusion and limitation rules apply.

Example: A group health plan provides benefits through an insurance policy issued by Issuer A. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer B. B's policy excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy. This is a preexisting condition exclusion because it excludes benefits based on the fact that the condition was present before the effective date of coverage under the policy. For individuals under age 19, this provision is impermissible starting with plan years beginning on or after September 23, 2010.

Lifetime and Annual Dollar Limits

PPACA generally prohibits group health plans from imposing lifetime or annual limits on the dollar value of "essential health benefits." This prohibition applies to group health plans, *without regard to their grandfathered status*, for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans), except that "restricted annual limits" on essential health benefits are allowed for plan years beginning before January 1, 2014. PPACA's prohibition on lifetime and annual dollar limits does not prohibit a complete exclusion of benefits for any particular condition (although other laws, such as the Americans With Disabilities Act, might), but if coverage is provided to any extent with respect to a condition, PPACA's annual and lifetime dollar limit rules apply.

Practice Pointer: Only essential health benefits are subject to these rules. Plans may impose per beneficiary, lifetime and annual limits on non-essential health benefits.

What Are Essential Health Benefits?

PPACA defined “essential health benefits” to include, *but not be limited to*, the following categories and items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; 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. No guidance has been issued to date regarding which other benefits qualify as “essential health benefits.” Until guidance is issued, the regulators have stated that for plan years beginning before additional guidance is issued, they will take into account consistent and good faith efforts to comply with a reasonable interpretation of the term “essential health benefits.”

Practice Pointer: An interpretation of the term “essential health benefits” is not reasonable or consistent if a plan applies a lifetime limit to a particular benefit—thus taking the position that it is not an essential health benefit—and at the same time treats that particular benefit as an essential health benefit for purposes of applying the restricted annual benefit.

Restricted Annual Limits on Essential Health Benefits

The Interim Regulations adopt a three-year phase-in approach for restricted annual limits on essential health benefits. Annual limits on the dollar value of essential health benefits may not be less than the following amounts *per individual* for plan years beginning before January 1, 2014:

- \$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, 2013

Practice Pointer: While not specifically addressed in the regulations, a non-monetary limitation (e.g., a limitation on the number of days or incidences of treatment) seems to be permissible under these rules. For example, plans could, instead of an annual maximum on hospitalization, limit the number of hospital visits covered under the plan.

The Interim Regulations specifically exempt health flexible spending arrangements (FSAs) as defined in Code Section 106(c)—which may also include many health reimbursement arrangements (HRAs) where the benefit is less than five times the value of coverage. In addition, the preamble to the Interim Regulations states that the annual limit rules do not apply to Medical Savings Accounts (MSAs), Health Savings Accounts (HSAs) or retiree-only HRAs. Also, when HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the annual limit restriction, the fact that benefits under the HRA by itself are limited does not violate the annual limit restriction. Despite the exemption for “health flexible spending arrangements,” the preamble specifically requests comments regarding application of these rules to stand-alone HRAs that are not retiree-only plans.

HHS Waivers: The preamble notes that for plan years beginning before January 1, 2014, the Department of Health and Human Services (HHS) may establish a program under which a waiver may be provided to 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, this may provide much needed relief to so called “mini-med” plans that are otherwise subject to these lifetime and annual limit restrictions.

Transition Rules

For any individual whose coverage or benefits ended due to reaching a lifetime limit and who becomes eligible (or is required to become eligible) on the first day of the first plan year on or after September 23, 2010, for benefits not subject to lifetime limits by reason of PPACA, the plan is required to give the individual a written notice that the lifetime limit no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. In addition, if the individual is not enrolled, or if an enrolled individual is eligible but not enrolled in any benefit package under the plan, then the plan must also give such an individual at least 30 days in which to enroll. This notice and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. Coverage for individuals who enroll in this manner must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

An individual eligible for an enrollment opportunity must be treated as a HIPAA special enrollee. Specifically, the individual must be given the right to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment, and cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit.

Prohibition on Rescissions

PPACA prohibits a group health plan from rescinding health coverage except in the case of fraud or intentional misrepresentation of a material fact. The prohibition on rescissions applies to plans and insurers (including grandfathered plans) for plan years beginning on or after September 23, 2010.

The Interim Regulations define rescission as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance is not a rescission if it has prospective effect, or if it is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. The Interim Regulations also require that a group health plan provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded, regardless of whether the rescission applies to an entire group or only to an individual within the group.

Example: Employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual C has coverage under the plan as a full-time employee. The employer reassigns C to a part-time position. Under the terms of the plan, C is no longer eligible for coverage. The plan mistakenly continues to provide health coverage to C. After a routine audit, the plan discovers that C no longer works at least 30 hours per week. The plan rescinds C's coverage effective as of the date that C changed from full-time employee to part-time employee. In this example, the plan cannot rescind C's coverage because there was no fraud or intentional misrepresentation of material fact.

Patient Protections

Background

PPACA imposes a set of three requirements relating to the choice of a health care professional and requirements relating to benefits for emergency services (collectively referred to as "patient protections"). The patient protections apply to plans beginning in plan years on or after September 23, 2010. None of the patient protections apply to grandfathered plans.

Choice of Health Care Professional

Generally, the requirements relating to choice of health care professionals apply only with respect to a plan with a network of providers. A plan or insurer that has not negotiated with any provider for the delivery of health care but merely reimburses individuals covered under the plan is not subject to the requirements relating to the choice of a health care professional. The patient protections provide that if a plan or insurer requires designation by a participant of a participating primary care provider, then the plan or insurer must permit such individual to designate any participating primary care provider who is available to accept the participant. Similarly, if the plan or insurer requires designation of a primary care provider for a child by a participant, the plan or insurer must permit the designation of a pediatrician as the child's primary care provider if the provider participates in the network of the plan or insurer and is available to accept the child. If a plan or insurer requires designation by a participant of a primary care provider or pediatrician, the plan or insurer must provide a notice informing each participant of the terms of the plan regarding such designation.

Plans or insurers that provide coverage for obstetrical or gynecological care and require the designation of an in-network primary care provider may not require authorization of referral by the plan, insurer or any person (including a primary care provider) for a female participant who seeks obstetrical or gynecological care. However, nothing precludes the plan or insurer from requiring an in-network obstetrical or gynecological provider to otherwise adhere to policies and procedures regarding referrals, prior authorization treatments and the provision of services pursuant to a treatment plan approved by the plan or insurer.

Notice

The Interim Regulations provide model language for providing notice to participants to (i) choose a primary care provider or pediatrician when a plan or issuer requires designation of a primary care physician, or (ii) obtain obstetrical or gynecological care without prior authorization. The notice must be provided whenever the plan or insurer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. The model language for the notice is as follows:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:
[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].
For plans and issuers that require or allow for the designation of a primary care provider for a child, add:
For children, you may designate a pediatrician as the primary care provider.
For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:
You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

Emergency Services

A plan or insurer providing emergency service benefits must do so without the individual or health care provider having to obtain prior authorization, and without regard to whether the health care provider furnishing the emergency services is an in-network provider with respect to the services. Generally, emergency services must be provided without regard to any other term or condition of the plan other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under ERISA, the PHSA or the Code, or applicable cost-sharing requirements. For a plan or insurer with a network of providers that provides benefits for emergency services, the plan or insurer may not impose any administrative requirement or limitation on benefits for out-of-network emergency services that is more restrictive than the requirements or limitations that apply to in-network emergency services.

The Interim Regulations define emergency services in accordance with the Emergency Medical Treatment and Labor Act (EMTLA) as, with respect to an emergency medical condition:

- a medical screening examination (as required under Section 1867 of the Social Security Act (42 U.S.C. § 1395dd)); and
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under Section 1867 of the Social Security Act (42 U.S.C. § 1395dd) to stabilize the patient.

Emergency Services and Cost-Sharing

The Interim Regulations impose certain cost-sharing requirements for emergency services. Cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out-of-network emergency services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. However, a participant may be required to pay (in addition to in-network cost-sharing) the excess of the amount of the out-of-network provider charges over the amount the plan or insurer is required to pay (so-called “balanced billing”), provided that the plan pays a reasonable amount.

In order to ensure that a plan pays a “reasonable amount” of the cost of emergency services, the Interim Regulations provide that a plan or insurer satisfies the copayment and coinsurance limits in the statute if it provides benefits for out-of-network emergency services in an amount equal to the greatest of the following three amounts:

- (1) The amount negotiated with in-network providers for the emergency service furnished;

- If there is more than one negotiated amount for a particular emergency service, the median of these amounts is used. In this regard, each amount negotiated with each provider must be treated as a separate amount in determining the median. For example, if for a given emergency service a plan negotiated a rate of \$100 with three providers, a rate of \$125 with one provider and a rate of \$150 with one provider, the amounts taken into account to determine the median would be \$100, \$100, \$100, \$125 and \$150, and the median would be \$100. If there is an even number of amounts, the median is the average of the middle two. Cost sharing imposed with respect to the participant is deducted from this amount before comparing with (2) and (3) below.
- (2) The amount for the emergency service calculated using the same method the plan generally uses to determine payment for out-of-network services, but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions;
- This amount is determined without reduction for out-of-network cost-sharing. For example, if a plan generally pays 70 percent of the usual, customary and reasonable amount for out-of-network services, the amount for (2) for an emergency service is the total (i.e., 100 percent) of the usual, customary and reasonable amount for the service, not reduced by the 30 percent coinsurance (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).
- (3) The amount that would be paid under Medicare for the emergency service.

Example: A plan imposes a \$60 copayment on emergency services without preauthorization, whether provided in network or out of network. If emergency services are preauthorized, the plan waives the copayment, even if it later determines the medical condition was not an emergency medical condition. In this example, by requiring an individual to pay more for emergency services if the individual does not obtain prior authorization, the plan violates the requirement that the plan cover emergency services without the need for any prior authorization determination.

For plans and health insurance coverage under which there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount in (1) above is disregarded, meaning that the greatest amount is going to be either the out-of-network amount or the Medicare amount.

The Interim Regulations impose an anti-abuse rule with respect to other cost-sharing requirements. Any other cost-sharing requirement, such as a deductible or out-of-pocket maximum, may be imposed on out-of-network emergency services only if the cost-sharing requirement generally applies to out-of-network benefits. The purpose of the rule is to prohibit a plan or health insurance coverage from structuring plan rules so as to require a participant to pay more for emergency services than for general out-of-network services.

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Brief Summary of the Highlights of the Health Care Reform Interim Final Regulations on the Mandated Coverage of Preventive Care Without Cost Sharing

By Greta Cowart

The U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of Treasury have released another set of interim final regulations (the "IFR") regarding the coverage of preventive care without cost sharing. As with all guidance, the IFR cannot be considered in isolation. Employers should consider how it fits and works with prior guidance, statutes and with the specific situation and benefit options within the employer's health plan, including the grandfathered status of each such option.

The mandated coverage of preventive care without cost sharing applies to benefit structures that are not grandfathered. The government has developed a Web page that has links to all of the lists of mandated preventive care and describes some of the requirements. The Web page is found [here](#).

Coverage of Preventive Care Without Imposition of Cost Sharing

The IFR attempts to divide whether a cost sharing element is imposed on a service by whether the preventative care service is billed separately from the office visit and, if it is not billed separately, by the primary purpose of the office visit. In addition, the IFR only requires that preventive care be provided without cost sharing by in-network doctors in a plan that has a network of providers; preventive care does not need to be covered without cost sharing if it is obtained from an out-of-network provider.

If the preventive care is billed separately from the office visit, there can be cost sharing (i.e., copayments or co-insurance, etc.) imposed on the office visit. For example, if you go to the doctor and he orders a blood test for your cholesterol and he bills you for the office visit and separately for the lab work, there cannot be any cost sharing with respect to the separately billed lab work for the blood test (because it is a preventive service), but he could impose cost sharing on the office visit (presuming the primary purpose of the office visit is not the cholesterol screening or other preventive care service).

If the office visit is not billed separately from the preventive care, then cost sharing may only be imposed on the office visit if the primary purpose of the office visit is not the delivery of the preventive care item or service (for example, if you go to the doctor for strep throat treatment and get a tetanus vaccine while you are there). It will be interesting to see how they will code the primary purpose of the visit in the electronic transaction and who will make that determination.

If the primary purpose of the office visit is obtaining the preventive care item or service, then there cannot be cost sharing imposed on the office visit if the office visit is billed together with the preventive item or service.

To see the lists of the preventive care required to be covered, please see the website above, or you can access the printed lists in one document [here](#).

For more information, please feel free to contact any [lawyer](#) in the [Employee Benefits Group](#).