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Health Care Reform Update: Changes Plan Sponsors Should Make This Year

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Over the last two months, the Departments of Labor, Treasury and Health and Human Services have issued a series of interim final rules implementing the market reform provisions of the Patient Protection and Affordable Care Act ("PPACA") that first become effective. (For information on PPACA, see our client alerts dated March 30 and May 13 and our white paper dated July 12, 2010.) These regulations adopt an expansive interpretation, in many respects, of the health care reform legislation and impose administrative changes that must be implemented by employers that sponsor health care plans before the commencement of the new plan year.

No Lifetime Limits. Insured group health plans and self-insured plans, including plans that are grandfathered under PPACA, must remove any lifetime dollar limits they impose on "essential health benefits," effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). Although regulations specifically defining "essential health benefits" are still forthcoming, the term will include emergency services, in-patient treatment, maternity care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and pediatric services. The regulations do not distinguish between in-network and out-of-network care.

Interim final rules issued on June 28, 2010 clarify that the prohibition on lifetime limits does not apply to health flexible spending accounts, medical savings accounts, health savings accounts or most health reimbursement arrangements. Employers may also continue to impose limits on benefits that do not constitute essential health benefits, such as limited scope dental and vision care. A plan's failure to cover a particular condition at all is not treated, for this purpose, as a lifetime limit, but employers must ensure that any hole in coverage complies with federal and state requirements.

Employers that sponsor plans with lifetime limits are advised to amend their plan documents and summary plan descriptions now, so that this change will be in place in time for annual enrollment. Plan sponsors that

want to retain lifetime limits on non-essential benefits should work with their administrators to implement a process to track those benefits separately. (Good-faith efforts to comply with a reasonable interpretation of "essential health benefits," if applied consistently, will be honored until regulations providing a more complete definition are issued.) Employers should also consider whether additional changes in plan design may be needed to avoid a corresponding increase in premiums.

Plans that have imposed lifetime limits in the past must provide a 30-day enrollment opportunity, commencing no later than the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans), to individuals whose coverage ended by reason of reaching a lifetime limit but are otherwise eligible for coverage. These individuals have the right to enroll in any benefit packages available to similarly situated individuals upon initial enrollment. Employers must notify any individuals eligible for re-enrollment that the lifetime limits no longer apply and of their right to re-enrollment. (The Department of Labor has posted a model notice on its website at http://www.dol.gov/ebsa.) The notice may be provided separately or included in a prominent place in the enrollment materials for the coming plan year.

Restrictions on Annual Limits. Insured group health plans and self-insured plans, including grandfathered plans, must restrict any annual dollar limits they impose on essential health benefits to new regulatory limits, effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). Under interim final rules issued on June 28, 2010, the annual limits, which apply on an individual-by-individual basis, are as follows:

- $750,000 for plan years beginning on or after September 23, 2010 and before September 23, 2011 (the plan year beginning on January 1, 2011, for calendar-year plans);
- $1,250,000 for plan years beginning on or after September 23, 2011 and before September 23, 2012 (the plan year beginning on January 1, 2012 for calendar-year plans); and
- $2 million for plan years beginning on or after September 23, 2012 and before January 1, 2014 (the plan year beginning on January 1, 2013 for calendar-year plans).

Effective for plan years beginning on or after January 1, 2014, annual limits may not be imposed on essential health benefits at all.

As with the prohibition on lifetime limits, the restrictions on annual limits do not apply to health flexible spending accounts, medical savings accounts, health savings accounts or most health reimbursement arrangements, and do not apply to covered benefits other than essential health benefits, to be defined under forthcoming regulations.

Employers that sponsor a limited benefit ("mini-med") plan may apply for a waiver from the new regulations if compliance would result in a significant decrease in access to benefits or a significant increase in premiums. Details on how to apply for the program are expected to be issued soon.

A grandfathered plan that does not currently impose an annual limit on essential health benefits will cease to be grandfathered under PPACA if it imposes an annual limit that is lower than any lifetime limit in place on March 23, 2010, even if the new limit does not exceed the applicable restriction set out in the interim final rules. Similarly, a plan that imposed an annual limit on March 23, 2010 will cease to be a grandfathered plan if the plan decreases the dollar value of the limit, even if the new limit does not exceed the applicable restriction.

No Preexisting Condition Exclusions. PPACA expanded the restrictions on preexisting condition exclusions put into place under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to provide that no insured group health plan or self-insured plan, including a grandfathered plan, may impose any preexisting condition exclusion against a child under the age of 19, effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). Effective as of January 1, 2014, no insured group health plan or self-insured plan may impose any preexisting condition exclusion on a participant of any age.

Interim final rules released on June 28, 2010 adopt HIPAA's expansive definition of "preexisting condition exclusion," which includes both denials of coverage of a specific benefit and complete exclusions from a plan or insurance coverage on account of a preexisting condition.

Employers are advised to amend their plan documents and summary plan description now, so that this change will be in place in time for annual enrollment. Employers should also consider preparing special employee communications that announce this change, which polls have shown to be among the most popular of the market reforms put into place by PPACA.

No Rescission. No insured group health plan or self-insured plan, including a grandfathered plan, may rescind coverage of any individual once the individual has become a covered participant, unless he or she committed fraud or made an intentional misrepresentation of material fact. This provision of PPACA, effective for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar-year plans), is intended to protect individuals who make inadvertent errors in their enrollment questionnaires.

Interim final rules released on June 28, 2010 define "rescission" narrowly for this purpose: a cancellation or discontinuance of coverage, other than for failure to pay premiums, that has a retroactive effect. Prospective cancellations of coverage, therefore, are not affected. The regulations also state that an employer or insurer may treat an omission of information as a "fraud" justifying rescission if the circumstances so indicate.

The regulations clarify that the prohibition applies to rescissions of groups, such as all employees of an employer, and that it takes into account representations made by the employer or another third party in seeking coverage for an individual. Therefore, if an employee becomes covered by a health plan because an employer's misclassification of the employee's work status, it appears that his health coverage could not be rescinded under the interim final rules without a showing of fraud or intentional misrepresentation.

The regulations also provide that the plan or insurer must provide 30 days' advance notice to each affected participant prior to rescinding coverage. This notice period is intended to provide individuals and plan sponsors an opportunity to explore their rights to contest the rescission or look for alternative coverage.

Employers should review their plan documents, annual enrollment materials and summary plan descriptions to ensure that they incorporate this rule. In addition, employers that maintain policies and procedures for administration of their health plans should review those procedures to ensure that they include safeguards for verifying the eligibility of potential participants prior to enrollment.

No Cost Sharing for Preventive Care. Insured group health plans and self-insured plans (other than grandfathered plans) may not impose any cost-sharing requirements, including copayments, coinsurance charges or deductibles, on preventive care, including certain immunizations, child preventive care and women's preventive care and screenings, for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans). "Preventive care," for this purpose, is defined by reference

to the recommendations and guidelines of the Centers for Disease Control and Prevention, the United States Preventive Services Task Force and the Health Resources and Services Administration, which must be adopted within one year of being issued. (A complete list of the applicable recommendations and guidelines and the dates on which they were issued is available at http://www.healthcare.gov/center/regulations/prevention/recommendations.html. This site is intended to be regularly updated.)

When a published guideline does not specify the frequency, methods, treatment or setting for the provision of a preventive care service, interim final rules issued on July 19, 2010 allow employers to use reasonable medical management techniques to determine any coverage limitations (for example, by imposing a limit on the number of screenings or requiring immunizations to be provided in a health care facility). If a plan stops covering a preventive service because it is removed from the published guidelines, employers should consider whether the change is a material modification that requires advance notice under PPACA.

The interim final rules give welcome relief to employers whose plans participate in a network of providers by limiting the application of the prohibition on cost-sharing to in-network services. Plans that currently impose cost-sharing requirements on out-of-network preventive services may continue to do so. The regulations also clarify that employers may continue to impose cost-sharing requirements on any office visit at which a preventive service is provided, if the service is billed or tracked separately from the office visit or the primary purpose of the office visit is not the delivery of the preventive service.

Employers that have implemented new plans since March 23, 2010 or have older plans not operated in compliance with the conditions on grandfathered status are advised to review the list of preventive care recommendations to determine whether they must amend their plan documents and summary plan descriptions in time for annual enrollment. Recommendations and guidelines issued prior to September 23, 2009 must be covered for plan years beginning on or after September 23, 2010. Employers should work with their administrators to create procedures for tracking preventive care items to ensure the proper implementation of the prohibition on cost-sharing, and must determine what coverage limitations to impose on the provision of preventive care services for which the published guidelines do not specify the frequency, methods, treatment or setting.

Choice of Health Care Providers. PPACA included patient protections directed at insured group health plans and self-insured plans (other than grandfathered plans) that participate in a network of providers. In particular, if a covered plan provides for designation of a participating primary care provider, then the plan must permit each participant to designate any participating primary care provider who is available. If the plan provides for designation of a pediatrician for a child, then the participant must be allowed to designate any participating physician who specializes in pediatrics if the provider is available to accept the child. If the plan provides coverage for obstetrical or gynecological care and requires the designation of an in-network primary care provider, it may not require a female participant seeking obstetrical or gynecological care to obtain authorization or referral by the plan, the insurance provider, her primary care physician or any other person. These changes are effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans).

Interim final rules published on June 28, 2010 require employers that have plans that are subject to these requirements to notify participants of their rights to choose a primary care provider or a pediatrician when the plan or insurer requires designation of a primary care physician and to obtain obstetrical or gynecological care without prior authorization, as applicable. Employers should amend their summary plan descriptions and enrollment materials prior to annual enrollment to ensure that to include the appropriate patient

protection notices. (The Department of Labor has posted model language on its website at http://www.dol.gov/ebsa.)

Access to Emergency Room Services. PPACA's patient protections do not permit insured group health plans or self-insured plans (other than grandfathered plans) to require prior authorization for emergency services (including out-of-network services), to limit emergency coverage to participating network providers, to impose administrative requirements or limitations on coverage for out-of-network coverage that are more restrictive than the requirements or limitations that apply to emergency services received from in-network providers or to impose any other term or condition on coverage of emergency services, other than the exclusion or coordination of benefits, a waiting period, or cost sharing requirements. In addition, any copayment amount or coinsurance rate for out-of-network emergency services may not exceed any cost-sharing requirements the plan would impose if the services were provided in-network. These rules are effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar-year plans).

Interim final rules released on June 28, 2010 clarify that the limitation on copayment amounts and coinsurance rates for out-of-network emergency services is not intended to prohibit employers from balance billing. Therefore, the regulations permit employers to require participants to pay the excess of the amount charged by the out-of-network provider for an emergency service over the greatest of (i) the median amount negotiated with in-network providers for the same service, (ii) the amount for the service, calculated using the same method the plan generally uses to determine payments for out-of-network services, and (iii) the amount that would be paid for the service under Medicare, in each case without reduction for copayments or coinsurance. The interim final rules also permit employers to continue to impose cost-sharing requirements other than copayments and coinsurance rates on out-of-network emergency services. For example, employers may impose deductibles or an out-of-pocket maximum on out-of-network emergency services, provided the requirements generally apply to out-of-network benefits, so that the enrollee will not be required to pay more for emergency services than for general out-of-network services.

Although the interim final rules provide needed relief for employers, many plans that participate in provider networks currently run afoul of these restrictions. Therefore, employers with non-grandfathered plans must take particular care that their plans are timely and appropriately amended and that the new standards are communicated to participants in the summary plan description and annual enrollment materials.

If you have any questions about the new interim final rules and their application to your company's health care arrangements, please contact the Pillsbury attorney with whom you usually work or one of the following members of our Compensation & Benefits practice section.

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