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THOU SHALT NOT EXCLUDE, RESCIND, OR LIMIT: AGENCIES RELEASE REGULATIONS IMPLEMENTING "PATIENT'S BILL OF RIGHTS"

The Patient Protection and Affordable Care Act, as amended ("PPACA"), contains several provisions designed to ensure greater individual access to health care. These provisions have been dubbed the "Patient's Bill of Rights." On June 22, 2010, the Departments of Labor, Treasury, and Health and Human Services ("Agencies") issued interim final regulations implementing the Patient's Bill of Rights.

As discussed in this *Commentary*, the Patient's Bill of Rights requires employer-sponsored group health plans[1] to:

- prohibit preexisting condition exclusions,
- prohibit lifetime dollar limits on coverage,
- prohibit annual dollar limits on essential health benefits,
- generally prohibit rescissions,
- require open access to network primary care physicians, pediatricians, and ob/gyns, and
- require that emergency services be covered out-of-network at the same level as in-network.

Grandfathered plans[2] are subject to the first four requirements in the Patient's Bill of Rights, but they are not required to provide open access to doctors

1 The Patient's Bill of Rights provisions also apply to health insurance policies issued by insurance companies. Except as expressly noted, the discussion in this *Commentary* about group health plans applies equally to health insurance polices issued to such plans.

2 Generally, "grandfathered plans" are plans in existence on March 23, 2010 that have continuously covered at least one person since that time and have not made significant changes in cost or coverage. For a more detailed discussion about grandfathered plans, see the Jones Day *Commentary* entitled "The More Things Change, the More They Stay the Same: Is It Worth Maintaining Grandfathered Status Under the New Health Care Law?" (June 2010), published on the Jones Day web site.

or provide parity in coverage of emergency services. Most of these provisions are effective for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans). The prohibition of preexisting condition exclusions for participants age 19 and over and the complete prohibition of annual dollar limits on benefits is effective for plan years beginning on or after January 1, 2014.

In complying with the Patient's Bill of Rights, employers and group health plans may need to amend plan documents, summary plan descriptions ("SPDs"), and other communications; update relevant procedures; and provide additional notices and enrollment opportunities to certain individuals.

This *Commentary* will discuss the various requirements set forth in the Patient's Bill of Rights regulations, their impact on plan design, and the obligations of plan sponsors to provide notice and special enrollment opportunities. Plan sponsors will need to be mindful of these rules as they prepare for the upcoming open enrollment season.

For a more detailed overview of PPACA, see the Jones Day White Paper, "Impact of Health Care Reform Legislation on Employer-Sponsored Group Health Plans" (April 2010), which can be found on the Jones Day web site.

NO PREEXISTING CONDITION EXCLUSIONS

The Patient's Bill of Rights prohibits group health plans (including grandfathered plans) from imposing *any* preexisting condition exclusions. Initially, the prohibition applies only to individuals under age 19. For plan years beginning on or after January 1, 2014, the prohibition will apply with respect to all individuals, regardless of age.

The new requirement does not eliminate the current rules regarding preexisting condition exclusions. As such, group health plans must continue to provide certificates of creditable coverage. In addition, for individuals who do not qualify for the new prohibition on preexisting condition exclusions, a preexisting condition exclusion may be imposed for up to 12 months for new enrollees and 18 months for late enrollees under the current rules.

LIFETIME AND ANNUAL LIMITS

The Patient's Bill of Rights also includes new restrictions on lifetime and annual dollar limits on benefits.

Lifetime and Annual Limits Restrictions. In general, group health plans (including grandfathered plans) may not impose a lifetime or annual dollar limit on benefits for any individual, except on specific covered benefits that are not "essential health benefits" (as defined below). Any such limitation must also comply with other federal or state laws, such as the Americans with Disabilities Act. The restriction on annual dollar limits is phased in over three years, as described in more detail below.

These restrictions do not prevent a group health plan from excluding all benefits for a specific condition. It also appears that these restrictions do not preclude a group health plan from imposing limitations other than dollar limits. For example, a group health plan apparently could impose a limitation on the number of chiropractic visits covered in a year and could impose treatment limitations based on lack of medical necessity.

The restrictions on annual limits do not apply to health care flexible spending arrangements ("FSAs"), health savings accounts ("HSAs"), or medical savings accounts ("MSAs"). In addition, health reimbursement arrangements ("HRAs") that are integrated with a group health plan may limit the annual amount of benefits available for reimbursement if the combined benefits under the integrated plan would satisfy these requirements.

Essential Health Benefits. Regulations have not yet been issued defining "essential health benefits." However, PPACA provides that any such definition shall, at a minimum, include coverage of:

- 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;
- chronic disease management; and
- pediatric services, including oral and vision care.

Before the regulations defining essential health benefits are issued, the Agencies will take into account good faith efforts to comply with a reasonable interpretation of what constitutes essential health benefits, as long as plans apply the interpretation consistently.

Three-Year Phase-In of Annual Limit Restriction. To mitigate potential premium increases, while at the same time ensuring access to essential health benefits, the prohibition on annual limits for essential health benefits is phased in over a three-year period.

For plan years beginning on or after September 23, 2010 but before January 1, 2014, a plan may not impose annual limits on essential health benefits that are less than the applicable amounts listed in the following table:

Plan Years Beginning	Restricted Annual Limit
before September 23, 2011	$750,000
on or after September 23, 2011 but before September 23, 2012	$1,250,000
on or after September 23, 2012 but before January 1, 2014	$2,000,000

These minimum limits apply on an individual basis and apply only with respect to limits on essential health benefits.

A plan that currently imposes a higher annual dollar limit on benefits than the permitted limit shown above may lower that limit to the permissible level. However, a plan that lowers the restricted annual limit will lose its grandfathered plan status and become subject to all of the PPACA mandates. Plan sponsors should carefully consider the full impact of the PPACA provisions before lowering any annual dollar limits.

Further guidance is expected establishing a waiver program for plans with limited benefit coverage, such as college student health plans and mini-medical plans. It is expected that the waiver program would exempt qualifying plans from the annual limits requirements. However, at present, it appears that such exemption would apply only until the first plan year beginning on or after January 1, 2014.

Transition Rule for Individuals Who Previously Exhausted a Lifetime Limit. The regulations provide a transition rule for individuals who have exhausted their maximum lifetime benefit under a plan. Under the transition rule, if such an individual is not enrolled in the plan, or an enrolled individual is eligible for but not enrolled in any benefit package under the plan, the group health plan must offer an opportunity to enroll. The enrollment opportunity must be offered not later than the first day of the first plan year beginning on or after September 23, 2010 and must continue for at least 30 days. Any coverage elected under the new enrollment opportunity must become effective not later than the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011, for a calendar year plan).

The plan must notify each such individual that the lifetime limit no longer applies and that the individual is once again eligible for benefits. The notice can be provided to an employee on behalf of a dependent. The notice may be provided with other open enrollment materials as long as the notice is prominent.

An individual who is eligible for enrollment under the new enrollment opportunity must be treated in the same manner as an individual with a special enrollment right. Accordingly, such individual must be offered all benefit packages available to similarly situated individuals who did not lose coverage due to reaching a lifetime limit on the dollar value of benefits. For these purposes, any difference in benefits or cost-sharing arrangements constitutes a different benefit package. An individual eligible for the new enrollment opportunity may not be charged more for coverage than similarly situated individuals not affected by the lifetime dollar limits.[3]

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3 Note that a similar notice and enrollment opportunity is required with respect to adult children who aged out of or did not qualify for coverage before the effective date of PPACA but become eligible because coverage must now be extended to age 26. Another Jones Day *Commentary*, "Coming of Age: Extended Health Coverage for Children to Age 26," published on the Jones Day web site, discusses the extended coverage for adult children.

RESCISSIONS

Group health plans (including grandfathered plans) may not rescind an individual's coverage, except in specific limited circumstances. A "rescission" is defined as the *retroactive* cancellation or discontinuance of coverage. A cancellation or discontinuance of coverage that has only prospective effect is not a rescission.

The specific limited circumstances under which a plan may rescind coverage are (i) the failure to timely pay the required premiums for the rescinded period of coverage, and (ii) the individual (or a person seeking coverage on the individual's behalf) performs an act, practice, or omission that constitutes fraud or intentional misrepresentation of a material fact, as prohibited by the terms of the plan. The plan must provide at least 30 days' advance written notice to each participant who would be affected before coverage may be rescinded (without regard to any period of contestability).

> **Example.** Employee A is covered under a health plan as a full-time employee. Under the terms of the plan, coverage may be cancelled in the event of fraud or misrepresentation. Upon a transfer to a part-time position, A is no longer eligible for coverage. The plan, however, mistakenly continues covering the employee. On audit, the plan discovers the mistake and rescinds coverage retroactive to the date of the transfer to a part-time position. The plan cannot rescind A's coverage because there was no fraud or intentional misrepresentation of a material fact (although the plan can cancel coverage prospectively).

Issues of fraud or misrepresentation with respect to a group health plan are most likely to arise in the context of an employee attempting to cover ineligible dependents. If a plan sponsor wishes to have the ability to rescind coverage under these circumstances, the sponsor should ensure that the plan terms provide for the rescission. However, it should be noted that fraud or intentional misrepresentation may be difficult to prove. Plans that currently require submission of proof of dependent eligibility (in the form of marriage certificates, etc.) and retroactively terminate coverage if the proof is not timely provided should consider changing their procedure to require proof in advance of enrollment.

CHOICE OF HEALTH CARE PROFESSIONALS

The Patient's Bill of Rights also sets forth requirements relating to the choice of a health care professional. *These requirements to do not apply to grandfathered plans*.

A plan with a network of providers that requires or provides for the designation of a primary care provider ("PCP") by a participant or beneficiary must permit that person to designate any available, participating PCP. If such a plan requires or provides for the designation of a PCP with respect to a participant's child, the plan must permit the participant to designate any available, participating pediatrician as the child's PCP.

A plan that provides coverage for ob/gyn care and requires the designation of a PCP may not require any authorization or referral for a female participant who seeks in-network ob/gyn care. In addition, a plan must treat any care or services obtained directly from the ob/gyn professional as authorized by the PCP.[4] A plan, however, may require an ob/gyn professional to adhere to the plan's policies and procedures, including those regarding referrals, prior authorizations, and the provision of services pursuant to a treatment plan approved by the plan. A plan may also require an ob/gyn professional to notify the PCP or the plan of the treatment decisions.

A plan that requires the designation of a PCP must provide a notice informing each participant of the terms of the plan regarding the designation of a PCP and of the participant's access rights to primary, pediatric, and ob/gyn care. The notice must be provided whenever the plan provides a participant with an SPD or other similar description of benefits under the plan. The regulations contain model language that plans can use to provide the required notice.

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4 For these purposes, an ob/gyn professional is any individual (including a person other than a physician) who is authorized under applicable state law to provide obstetrical or gynecological care.

COVERAGE OF EMERGENCY SERVICES

Manner of Providing Emergency Services. A plan that provides any benefits with respect to services in an emergency department of a hospital must cover emergency services in the following manner:

- without the need for any prior authorization, even if services are provided out-of-network;
- without regard to whether or not the provider furnishing the emergency service is a participating network provider;
- without imposing any administrative requirements or limitations on coverage provided out-of-network that are more restrictive that those that apply to services provided by an in-network provider; and
- if services are provided out-of-network, by complying with the cost-sharing requirements under the regulations (as discussed below).

Cost-Sharing Requirements. *Copayment and Coinsurance.* A plan may not impose a higher copayment or coinsurance requirement on a participant for emergency services provided out-of-network relative to the copayments and coinsurance amounts charged by the plan for in-network emergency services. In addition, a plan may not pay less for an out-of-network emergency service than *the greatest of* the following for such service: (i) the In-Network Negotiated Payment Amount (as defined below), (ii) the Out-of-Network Payment Amount (as defined below), or (iii) the amount that would be paid by Medicare. Plans are not required, however, to cover the balance of the charges remaining after the copayment and coinsurance, and balance billing is not prohibited.

For purposes of these rules:

- **"In-Network Negotiated Payment Amount"** means the payment amount, if any, negotiated with in-network providers, excluding any in-network copayments or coinsurance. If more than one payment amount has been negotiated with different providers, the in-network negotiated payment amount is the median[5] of all negotiated amounts (treating an amount negotiated with each provider as a separate amount, even if the amount is the same for several providers).
- **"Out-of-Network Payment Amount"** means the amount calculated using the method the plan generally uses to determine payments for out-of-network services (such as usual, customary, and reasonable charges), without any reduction for out-of-network cost sharing that generally would apply with respect to out-of-network coverage and applying instead the applicable in-network copayment or coinsurance amounts. Thus, for example, if a plan pays 70 percent of the usual, customary, and reasonable charges for out-of-network services, the Out-of-Network Payment Amount is 100 percent of such charges, less any in-network copayment and coinsurance.

Other Cost-Sharing. Any cost-sharing requirements other than copayments and coinsurance (*e.g.*, deductibles and out-of-pocket maximums) may be imposed with respect to emergency services if such cost-sharing requirements generally apply to out-of-network benefits. Thus, a deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. Similarly, if an out-of-pocket maximum generally applies to out-of-network benefits, then the out-of-pocket expenses a participant incurs for emergency services must count toward satisfying such maximum.

CONCLUSION

The requirements of the Patient's Bill of Rights affect plans to varying degrees. All plan sponsors, however, will need to take these requirements into account as they prepare for the upcoming open enrollment season. Sponsors of grandfathered as well as nongrandfathered plans will need to ensure that their plan documents, SPDs, enrollment packages, and other employee communication materials are properly revised to reflect the new coverage mandates described above, and that proper notices are prepared and provided for anyone who previously reached a lifetime limitation under a plan.

5 In the case of an even number of negotiated amounts, the median is the average of the middle two amounts.

Sponsors of nongrandfathered plans (including those plans that lose or relinquish their grandfathered status) that require the designation of a PCP also must review and, if necessary, amend their plans to comply with the requirements for access to participating PCPs, pediatricians, and ob/gyn care. Additionally, such plans must be reviewed for compliance with the expanded access and cost-sharing requirements for emergency services. Sponsors will also need to ensure that notice of the participants' rights under these "access" rules are properly prepared and provided.

Sponsors offering student health plans and mini-medical plans are likely to be the most significantly affected by the new restrictions on the annual dollar limits. Thus, they will need to start working with their insurers and/or third-party administrators in implementing the necessary design changes or exploring other alternatives for providing health coverage for their participants. Such sponsors could also seek a waiver of the requirements to the extent a waiver program is established by the Secretary of HHS (discussed above).

This is one in a series of *Commentaries* Jones Day intends to provide to our clients and friends on the provisions of PPACA. We will provide additional guidance on how the provisions of PPACA, and the developing regulatory framework, affect employer-sponsored health plans and their sponsoring employers as developments occur.

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