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REFORM Update

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Another week and another round of regulatory guidance was released to help employers and health plans comply with Health Care Reform. This guidance, jointly issued by the same governmental agencies as the grandfathering rules, clarifies a number of near term requirements including:

- Prohibition on Pre-Existing Condition Limitations
- Prohibition on Lifetime Dollar Limits
- Restrictions on Annual Dollar Limits
- Prohibition on Coverage Rescissions
- Patient Protections (Primary Care Physician Rules and Emergency Room Coverage)

Effective dates vary for each requirement and some are subject to the grandfathering rules. This Update addresses the new information for each of the requirements and the dates they will impact your plan.

Prohibition on Pre-Existing Condition Limitations

The prohibition on pre-existing conditions follows a two-step compliance process. In the first step, health plans must eliminate pre-existing condition limitations on participants up to age 19. Step one is effective as of the first day of the first plan year following September 23, 2010 and does not allow for grandfathered plans to delay compliance.

In step two, health plans must completely eliminate pre-existing condition limitations for all plan participants. Step two is effective as of the first day of the first plan year on or after January 1, 2014 and does not allow for grandfathered plans to delay compliance.

The regulations define a pre-existing condition exclusion as a limitation or exclusion of benefits (including denial of coverage) based on the fact that a condition was present before the effective date of coverage (or if coverage is denied, the date of denial) under a group health plan or group or individual insurance coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. A pre-existing condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under the group health plan or group or individual insurance coverage. The condition may have been identified as the result of a pre-enrollment questionnaire, a physical examination given to the individual or a review of medical records relating to the pre-enrollment period.

Please note that even if your plan does not include an explicit pre-existing condition limitation, you still may need to modify some aspects of your plan. The regulations include an example of a plan provision that excludes coverage for oral surgery required as a result of traumatic injury if the injury occurred prior to the effective date of coverage. In the example, an individual switches insurance coverage and does indeed need oral surgery for an injury that occurred prior to the coverage effective date. The plan cannot deny coverage for the oral surgery on the basis that it is needed to treat an injury that occurred prior to the effective date of coverage.

Employers will need to amend their plans in two stages:

1. Exclude participants up to age 19 from any pre-existing condition limitations (first day of first plan year following September 23, 2010)
2. Remove any pre-existing condition limitations from the plan altogether (first day of first plan year on or after January 1, 2014)

Employers will also need to review their plan documents for provisions that may not be considered pre-existing condition limitations but due to plan language they would qualify for as a pre-existing condition limitation. The exclusion for treatments of injuries incurred prior to the effective date of coverage is fairly common.

The regulations include an example addressing the removal of pre-existing condition limitations on participants under age 19. In the example, the plan year is measured on a January 1 basis and includes a pre-existing condition limitation. A new employee is added to the plan and covers one dependent child (age 12) on October 1, 2010. Previously, the employee and child had a significant break in coverage because of a 6 month lapse in coverage before finding a new job. The child has asthma and it is considered a pre-existing condition by the plan. From October 1 – December 31, 2010, the plan can deny any claims related to the treatment of asthma, because it is a pre-existing condition. However, the plan is required to remove all pre-existing condition limitations for plan participants under age 19 effective January 1, 2011. As of January 1, 2011, any claims related to the asthma would be covered by the plan. The pre-existing condition limitation still applies to the employee.

The regulations spend no time discussing how these changes may impact the requirement to provide Notices of Creditable Coverage under the HIPAA regulations. Once pre-existing conditions are prohibited on all health plans, the certificate of credible coverage would no longer serve a useful purpose. It is likely changes to these requirements will be addressed in future guidance.

Prohibition on Lifetime Dollar Limits

The prohibition on lifetime dollar limits appears fairly straight forward. A group health plan or health insurance carrier offering group health coverage may not establish any lifetime limit on the dollar amount of

benefits paid for any individual. This provision is effective as of the first day of first plan year following September 23, 2010 and does not allow for grandfathered plans to delay compliance.

The guidance includes transition rules for individuals whose coverage or benefits ended because they reached a plan's lifetime limit. If an individual in this situation is eligible for benefits under the group health plan, the plan and insurance carrier must provide a written notice that lifetime limits no longer apply and the individual is once again eligible for benefits. If the individual is not enrolled in the plan or in a specific benefit package under the plan, the plan must provide a 30-day window for the individual to enroll. If an individual in this situation chooses to enroll, coverage must be effective no later than the first day of first plan year following September 23, 2010.

All plans must provide a notice about the removal of lifetime limits and explain how someone who lost coverage due to reaching the lifetime limit can now enroll in the plan. The notice may be provided to employees on behalf of dependents and it may be included as part of other enrollment materials distributed to employees provided as it is "prominent" in the document.

Any individual enrolling as a result of the elimination of lifetime maximums is treated as a HIPAA special enrollee, which means:

- Individual must be offered all coverage options available to similarly situated participants who did not lose coverage due to reaching the lifetime maximum
- Individual cannot be required to pay more for coverage than similarly situated dependents who did not lose coverage due to reaching the lifetime maximum
- Employer must allow an individual to switch benefit plan options in addition to enrolling an individual who lost coverage due to reaching the lifetime maximum
- If a dependent lost coverage due to reaching the lifetime maximum and the employee discontinued benefits as a result and the employee is still eligible for coverage, the plan must allow the employee and the dependent to enroll for coverage

Plan participants rarely hit lifetime benefit limits and many employers will not have any employees or dependents that have lost coverage for this reason. However, all employers need to remove lifetime maximums and include a notice about the change with enrollment materials. And, all employers need to be prepared to allow for re-enrollment in the plans for any eligible plan participant that lost coverage due to hitting the maximum.

Restrictions on Annual Dollar Limits

Like the pre-existing condition limitations, the restriction on annual dollar limits follows a two-step process. Step one requires that all "essential benefits" include only "restricted" annual dollar benefit maximums. This

requirement is effective the first day of the first plan year following September 23, 2010 and does not allow for grandfathered plans to delay compliance.

Regulations reserve the right to make future changes to the categories of **essential benefits**, but provide the following list today:

- 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
- Pediatric services, including oral and vision care

Regulations define **restricted annual limits** as no less than the following:

1. Plan years on or after September 23, 2010 and before September 23, 2011 = $750,000
2. Plan years on or after September 23, 2011 and before September 23, 2012 = $1,250,000
3. Plan years on or after September 23, 2012 and before September 23, 2013 = $2,000,000

Step two prohibits any annual dollar maximums on essential benefits. The requirement applies to plan years beginning on or after January 1, 2014 and does not allow for grandfathered plans to delay compliance.

The rules clarify a number of aspects of step two of compliance:

- Limit rules do not apply to health care spending accounts, even though viewed as self-funded medical plans
- Limit rules do not apply to HSAs or Archer MSAs, which are not typically viewed as medical plans because the account funds are not required to be used on medical expenses
- Limit rules do not apply to HRAs providing the HRA is integrated with a comprehensive health plan that does not violate the annual or lifetime dollar maximum requirements
- Plans can place annual and lifetime dollar limits on specific covered benefits, provided they **are not** considered essential health benefits and limits would otherwise be permitted under State or Federal Law (appears to allow annual dollar benefit limits on non-essential benefits such as chiropractic benefits providing they don't qualify as rehabilitative services)

Finally, the regulations provide Secretary of Health and Human Services with waiver authority. For plan years beginning before January 1, 2014, the Secretary may establish a program where restrictions on annual limits will be waived because compliance with the new restricted limits would result in a significant decrease in access to benefits or a significant increase to premiums or cost for coverage.

The waiver right appears targeted at "mini-med" plans that some employers offer - by definition a mini-med plan provides restricted benefits for affordable premiums. No details are provided on the waiver process, but it may allow employers to continue offering mini-med plans until January 1, 2014 when the individual mandate goes into effect. Guidance on the waiver is expected in the near future.

Prohibition on Coverage Rescissions

The prohibition on rescissions states that a group health plan or health insurance carrier must not rescind coverage with respect to an individual, once the individual is covered under the plan, unless the individual performs an act, practice or omission that constitutes fraud or if the individual makes an intentional misrepresentation of material fact as prohibited by the terms of the plan. The requirement is effective the first day of the first plan year following September 23, 2010 and does not allow for grandfathered plans to delay compliance.

A rescission is a cancellation or discontinuance of coverage with a retroactive effective date. Some clarifications related to whether a cancellation is considered a rescission include:

- A cancellation that treats a policy as void from the time of a group's enrollment is a rescission
- A cancellation that voids benefits paid up to a year before cancellation is a rescission
- Not all cancellations are considered rescissions – it is not a rescission when:
    - Discontinuance of coverage has only a prospective effective date
    - Discontinuance of coverage is retroactive, but due to a failure to timely pay required premiums or contributions
    - Product withdrawn from a specific marketplace
    - Employee moves outside service area of the plan
    - For association coverage, cessation of membership in the association

The regulations include an interesting example for employers. A full-time employee covered by the group health plan reduces work hours and changes to part-time status. Part-time employees are not eligible for coverage under the plan, but the employer fails to terminate to coverage and continues to collect contributions for coverage. The error is discovered several months later and the employer wants to retroactively terminate coverage, but the employer cannot retroactively terminate the coverage (it would be a rescission) and instead the employer can only cancel the coverage on a prospective basis.

The government has informally indicated that they will issue more guidance on cancellations in the future which should help employers comply with these rules more effectively.

Patient Protections (Primary Care Physician Rules, Emergency Room Coverage)

The regulations also include a section entitled "Patient Protections" that describes requirements to allow certain choices in primary care physicians and rules related to coverage of emergency room services.

Designation of a Primary Care Provider

If a group health plan or group insurance carrier requires the designation of a participating primary care provider, the plan must allow each participant to designate any participating primary care provider who is available to accept the participant. If a plan requires the designation of a primary care provider for a child covered by the plan, the plan must permit the participant to designate an allopathic or osteopathic physician who specializes in pediatrics as a primary care provider. The regulations note this does not impact exclusions of coverage under the terms and conditions of the plan with respect to pediatric care.

The regulations also have general rules regarding access to OB/GYN care. A group health plan or a group health insurance carrier may not require a referral for a female participant to seek coverage for OB/GYN care provided by a doctor participating in the plan and specializing in obstetrics or gynecology. The plan can require the OB/GYN to adhere to the plan's policies and procedures including procedures regarding referrals, prior authorizations and providing services according to a treatment plan. Nothing in this requirement compels a plan to offer coverage for OB/GYN services.

Plans must provide a notification of these rights and the regulations include model language:

- 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].

If your organization has a plan that requires the designation of a primary care physician, you should check with the insurance carrier to make sure they will follow the rules for designating a primary care physician and rules for OB/GYN care. It is also likely the carrier would handle the notification requirements but you should verify this with the carrier.

Coverage of Emergency Room Services

If a group health plan or health insurance issuer provides any benefits with respect to services received in the emergency department of a hospital, the plan or insurance carrier must cover the services in the following manner:

- Without the need for any prior authorization determination, even if the services are provided on an out of network basis
- Without regard to whether the health care provider furnishing the emergency room services is a participating network provider (limitations on how copays and coinsurance can be applied with out of network providers)
- If the services are provided out of network, the plan cannot impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency room services provided by in-network providers

The regulations do address a key question many employers had – if I treat an out-of-network provider as an in-network provider, can I pay for services using the in-network fee schedule? The regulations provide much discussion of cost-sharing requirements:

- Any cost-sharing requirement expressed as a copayment or coinsurance level that is imposed with respect to a participant for out of network services cannot exceed the cost-sharing requirement that would be imposed on a participant if the services were rendered in-network.
- The plan can pay the provider based on the in-network fee schedule and the provider can balance bill the participant for amounts above the network fee schedule. However, to protect the participant from very aggressive fee schedules, the plan is limited to determining benefits based on an amount that is the greatest of the following three amounts (which are adjusted for in-network cost sharing):
    1. Amount negotiated with in-network providers for the emergency services furnished, excluding any in-network copayment or coinsurance requirements. If the plan has different amounts

negotiated with different emergency room providers, the plan should use the median amount for this purpose. If the plan does not have a per service amount negotiated with providers (for example, a capitation or other similar payment arrangement) then this bullet is disregarded in determining the amount benefits should be based on.

2. The amount for emergency service calculated using the same method the plan generally uses to determine the payments for out of network services (the usual, customary, and reasonable amount) excluding any in-network copayment or coinsurance requirements.
3. The amount that would have been paid under Medicare for the emergency service excluding any in-network copayment or coinsurance requirements.

- For any other cost-sharing requirement that is not a copayment or coinsurance requirement (such as a deductible or out of pocket maximum) the plan can impose the out of network levels with respect to emergency services received out of network if the cost-sharing requirements generally apply to out of network benefits. For copayments and coinsurance requirements, the in-network level of benefit must apply, regardless of provider network status.

The regulations include a couple interesting examples:

- A plan imposes a 25% coinsurance on emergency room services, regardless of whether the provider is in or out of network. If the participant notifies the plan within two business days after the emergency room treatment, the plan will reduce the coinsurance to 15%. This plan design is well within the rules. The plan does not require prior authorization; the call is made after services are received.
- A plan imposes a $60 copayment on emergency room visits that are not preauthorized, regardless of whether the provider is in or out of network. If the participant preauthorizes the emergency room services, the plan waives the copayment. This plan design does violate the requirement that emergency services to be covered without the need for any prior authorization determination.

The requirements of the Patient Protection aspects of health reform are effective as of the first day of the first plan year following September 23, 2010, and the effective date can be delayed if a plan is considered grandfathered.

Concluding Thoughts

For all the aspects addressed by this latest round of guidance, the employer will need work closely with their health insurance carrier or TPA to make sure the plan complies appropriately.

The removal of the pre-existing condition limitation for participants under age 19 will require a modification of the pre-existing limitation in your plan. The tricky part of complying with this requirement will be reviewing your plan to determine if any plan provisions inadvertently apply a pre-existing condition limitation. The limitation on coverage for services needed due to an accidental injury commonly requires the injury to have

occurred while covered by the plan. In addition, some plans have limits on coverage for artificial limbs that base coverage on the fact the limb was lost while covered under the plan.

The lifetime and annual limits are fairly straightforward and will require plan modifications. If your plan is self-funded, please note: the prohibition on lifetime limits does not apply to stop loss coverage. It will be important to secure an unlimited stop loss contract to cover your plan risk completely. Several stop loss carriers have confirmed they will offer unlimited contracts. If your plan is unable to secure unlimited stop loss, you may want to consider staggering stop loss coverage. Secure a contract with one carrier to provide stop loss benefits up to two million dollars and contract with another vendor to pick up the risk after two million dollars.

Most group health plans rarely rescind coverage for a purpose not permitted by this law. However, the situation where an employer forgot to terminate coverage on an employee is far more common. It appears that your organization will no longer be able to retroactively terminate coverage. We expect more guidance on cancellations that should provide more parameters on how to handle coverage terminations.

Finally, the Patient Protection aspects of the law are very detailed but primarily will affect insurance carriers and TPAs. Your organization may need to modify emergency room coverage to meet the requirements of the law.

The government has indicated more guidance is coming soon on the preventive care coverage requirements and the new coverage appeal rules. Stay tuned…