HEALTH REFORM

Patient Bill of Rights

Interim Final Regulations Regarding Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

On June 22, 2010, the Departments of Treasury, Labor and Health and Human Services issued interim final regulations that provide detailed guidance for health plans and insurance policies – over 190-pages worth – on the prohibition of lifetime and annual limits, rescission of coverage, the exclusion of pre-existing condition clauses and additional patient protections. These regulations, which comprise the "patient's bill of rights," cover some of the major consumer protections provided under the Patient Protection and Affordable Care Act (PPACA), and apply to both fully insured and self-insured group health plans as well as to individual health insurance policies.

In short, the regulations:

1. Prohibit lifetime limits on what plans or policies will pay for care;
2. Ban annual limits of less than $750,000 on coverage of "essential health benefits," which include, among other things, in-patient and out-patient hospital services, prescription drugs and physician services (the minimum annual limit increases for plan years until it reaches $2 million for plan years ending on or after September 23, 2012 until 2014, when such limitations are prohibited);
3. Prohibit rescission of coverage except in clear cases of fraud;
4. Prohibit denial of coverage to children under 19 with pre-existing medical conditions, subject to some exceptions; and
5. Add certain patient protections, including the right to select any participating primary care provider, and prohibiting the requirement of referrals or prior approvals for a patient to receive treatment from an obstetrical and gynecological physician or to receive emergency services from a provider outside the patient's network.

Read on for a more detailed analysis of each provision.

Lifetime and Annual Limits

Generally, effective for plan years beginning on or after September 23, 2010, PPACA prohibits health plans and health insurance issuers from imposing any lifetime limits on the dollar amount of essential health benefits. In 2014, PPACA will also prohibit any annual limits for essential health benefits; until then, however, the regulations provide for phased in, restricted annual limits on such benefits. Plans may impose annual or lifetime limits on specific covered non-essential health benefit as long as such limits do not violate any other federal or state law. The term "essential health benefits" is broadly defined in the statute to include in-patient and out-patient hospital services, prescription drugs, and physician services among others.

The following table establishes the restricted annual limits on essential health benefits that will be allowed until 2014. The limitation amounts increase annually until the full prohibition on annual limits goes into effect in 2014.

Plan Years Beginning On or After	Plan Year Beginning Before	Allowed Annual Limit on Essential Health Benefits
September 23, 2010	September 23, 2011	$750,000
September 23, 2011	September 23, 2012	$1,250,000
September 23, 2012	January 1, 2014	$2,000,000

These prohibitions apply to all types of health insurance plans and policies. However, health flexible spending accounts, health savings accounts and Archer medical savings account plans are excluded from these requirements. In addition, certain plans may be eligible for a waiver from the annual restrictions if they can demonstrate that meeting the requirements would result in a significant decrease in access to benefits or cause a significant increase in premiums.

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Dependent Coverage

Participants who previously lost coverage due to a lifetime limit have a new special enrollment right beginning with the first plan year on or after September 23, 2010. Plan sponsors are required to notify impacted individuals, in writing, of the elimination of the lifetime limit and their eligibility for benefits under the plan. The plan must then give the individuals a special opportunity to re-enroll. The Department of Health & Human Services has prepared model notices for this purpose.

Please note that the restrictions on annual and lifetime limits apply to both new and "grandfathered" plans (those in effect on March 23, 2010).

Rescissions of Coverage

Health plans and insurers are prohibited from rescinding coverage once a participant is covered unless the participant intentionally misrepresented a material fact. If the plan determines that a rescission is allowed, then the plan must provide 30 days notice in advance of the rescission. For purposes of the regulations, a rescission is a cancellation or discontinuance of coverage that has a retroactive effect. This requirement applies to both new and grandfathered plans.

Pre-Existing Condition Exclusions

For plan years beginning on or after January 1, 2014, health plans and insurers may no longer impose pre-existing condition clauses. Prior to 2014, for plan years beginning on or after September 23, 2010, the rule applies only to individuals who are under age 19. Both grandfathered and non-grandfathered plans are subject to this prohibition.

Patient Protections

PPACA also provides new patient protections. Health plans and insurers must now allow participants to select any participating primary care provider who has availability to accept the participant. Also, if a plan requires designation of a primary care provider the plan must allow a parent to designate a pediatrician as the primary care provider for a child. The regulations include model language that can be used to notify participants of these new rights.

Authorizations and referrals can no longer be required for a patient to receive treatment from an obstetrical and gynecological physician. Additionally, coverage for emergency services in a hospital must cover emergency services provided at hospitals that are out-of network without any administrative requirements or limitations more stringent than those imposed on in-network hospital emergency services. Participant co-pays or co-insurance amounts cannot be higher than that imposed on in-network emergency services, however, participants may be required to pay any excess amount that the out-of-network hospital charges over the amount the plan or insurer pays to its in-network hospitals. These patient protections do not apply to grandfathered plans.

Additional Resources

- Copy of the interim final regulations: www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23983
- Fact sheet: www.healthreform.gov/newsroom/new_patients_bill_of_rights.html
- Lifetime limit model: www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc
- Patient protection model notice: www.dol.gov/ebsa/patientprotectionmodelnotice.doc

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