



**DATE:** June 29, 2010  
**TO:** Our Valued Client Partners & Friends  
**FROM:** HIB Account Team  
**RE:** **LEGISLATIVE UPDATE 2010-13**  
**Health Care Reform: Patients' New Bill of Rights**

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We are pleased to bring you our **Legislative Update 2010-13: Health Care Reform: Patients' New Bill of Rights**. This update offers a detailed analysis the Interim Final Rules on pre-existing condition limits, lifetime and annual limits, rescissions, and various patient protections. Your HIB Account Team will work with you on compliance.

As always, please feel free to contact your HIB Account Team for assistance.

### Health Care Reform: Patients' New Bill of Rights

On June 23, 2010, ninety days prior to the implementation of numerous Health Care Reform Law provisions, the Department of Treasury (IRS), Department of Labor (DOL), and the Department of Health and Human Services (HHS) released an [Interim Final Rule](#) regarding:

- Pre-existing condition limitations;
- Lifetime and annual limit prohibitions;
- Prohibition against rescissions; and,
- Various patient protections, including choice of a health care professional and scope of emergency services.

Each of these provisions takes effect to some degree, for plan years beginning on or after September 23, 2010. Whether group health plans are insured or self-insured, whether grandfathered or not, the new rules will apply with the following exception: Patient protections described under Public Health Service Act (PHSA) Section 2719A (Patient Protections), including choice of health care professional and scope of emergency services will not apply to grandfathered plans.

#### Section A: Pre-existing Condition Limitations (PHSA Section 2704)

1. **Effective Date.** As you know, the Health Reform Laws ban pre-existing condition limitations and exclusions; however, the law has a bifurcated implementation date:
  - Pre-existing conditions limitations and exclusions will no longer apply to dependent children under the age of 19, as of the first day of the plan year beginning on or after September 23, 2010 for all group health plans, insured or self insured, whether grandfathered or not.
  - Pre-existing condition limitations and exclusions are prohibited for all enrollees for plan years beginning on or after January 1, 2014.
2. **Definition of a Pre-existing Condition.** The Health Insurance Portability and Accountability Act (HIPAA), for purposes of its waiver for a pre-existing condition (i.e. the enrollee has changed health plan coverage with no more than a 63 day gap in coverage), defines a pre-existing condition as a limitation or exclusion of benefits related to a condition if that condition was present before enrollment in the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received prior to enrollment. To remove any ambiguity for purposes of Health Reform, Congress expanded this definition. The Health Reform Laws prohibit



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not just an exclusion of coverage for a specific pre-existing condition but also prohibit a complete exclusion of health plan coverage if there is a pre-existing condition. The HIPAA rule that an exclusion of benefits for a particular condition under a plan or policy without regard to when the condition arose remains in effect.

***Section B: Lifetime and Annual Limits (PHSA Section 2711)***

1. **Effective Dates.** The Health Reform Law itself calls for an absolute prohibition against lifetime limits as of the first day of the first plan year beginning on or after September 23, 2010 for all plans, insured and self-insured, whether grandfathered or not. The Interim Final Rule contains phase-in rules for the elimination of annual limits on essential health benefits, ultimately effective for plan years beginning on or after January 1, 2014.
2. **Notice Requirements: Lifetime Limits.** Individuals who are subject to lifetime limits and who have reached those limits prior to the applicability of these Interim Rules, who would otherwise be eligible for group health coverage, must be given notice that the lifetime limit no longer applies, and that they may re-enroll. The rule requires that **plan sponsors** provide the notice no later than the first day of the first plan year on or after September 23, 2010. The plan must treat these individual as HIPAA special enrollees, entitling them to enroll in any benefit option available to similarly situated employee as long as they do so within 30 days. Coverage would be effective as of the first day of the plan year.
3. **Essential Benefits.** Beginning in 2014 the law will require a minimum set of benefit provisions for all plans offered through the Exchange. Since the Exchange's plans will be insured and designed for groups under 100 lives and for individual policies, the new rules are silent concerning self-insured plans and insured plans sponsored by employers with more than 100 employees. The law gives broad discretion to the Secretary of Health and Human Services (HHS Secretary) as to what benefits may continue to contain annual limits, albeit restricted. In defining restricted annual limits, the Health Reform Law requires the HHS Secretary to ensure that access to necessary services remains available with only a minimal impact on premiums (PHSA Section 2711(a)(2)). The Interim Final Rules on annual limits reflect that standard.
4. **Permissible Annual Limits.** The Health Reform Law allows/provides for specific annual limits for Cafeteria Plan Health Care Spending Accounts: \$2,500 per employee effective for tax years beginning in 2013. The Interim Final Rule will permit the use of annual limits for Health Reimbursement Accounts (with rollover) (under IRS Notice 2002-45) which are "integrated with" other group health coverage. Annual limits also will apply to Medical Savings Accounts and Health Savings Accounts in accordance with federal law without violating Health Reform Rules, since they are not health plans.
5. **Annual Limits on Essential Benefits.** The new Rule will allow annual limits on essential benefits under group health plans, whether insured or self-insured, between now and January 1, 2014, but they may not be less than the following table:

Plan or Policy Years:	Annual Limit
Beginning on or after 9/23/2010 but before 9/23/2011	\$ 750,000
Beginning on or after 9/23/2011 but before 9/23/2012	\$ 1,250,000
Beginning on or after 9/23/2012 but before 1/1/2014	\$ 2,000,000



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6. **Annual Limits Apply on an Individual by Individual Basis.** Although the new Rule permits annual limits on essential benefits prior to 2014, it prohibits a family annual limit. The new Rule makes it clear that if a family limit is met, and another family member incurs eligible expenses, then those expenses must be reimbursed under the terms of the plan without regard to the fact that the family has already maximized the annual family benefit.
7. **Health Reimbursement Accounts (with Rollover of Unused Balances).** The new Rule explicitly allows these specific types of reimbursement plans to have annual limits so long as they are "integrated with" other group health coverage (e.g. HRA reimburses enrollee for outpatient surgery deductibles) when the other group health coverage itself complies with the Health Reform Laws. Health Reform Law allows for pre-2014 annual limits, but only for essential health benefits as defined by the Law and determined as such by the HHS Secretary. The new Rule also makes it clear that retiree-only HRAs are not subject to Section 2711.
8. **Medical Expense Reimbursement Plans.** Many plan sponsors supplement their existing group health plans by establishing a self-funded Medical Expense Reimbursement Plan (MERP) with annual limits ranging typically from \$500 to \$2,500 or more at no cost to health plan participants. Sometimes the benefit is targeted (hospital daily deductible); other times it is any medical expense qualified under IRC Section 213(d). If the benefits are unused at the end of the plan year, they are forfeited. Based on the Interim Final Rule inferences, MERPs should remain viable since they are integrated with other coverage (i.e. a group health plan). So, as long as the group health plan is in compliance, so, too, is the MERP. This exception may not apply to "stand alone" MERPs.
9. **Mini-Med Type Plans.** The Health Reform Law requires that any restrictions on annual limits must continue to ensure access to necessary services with a minimal impact on premiums. The new Rule delegates this responsibility to the HHS Secretary who must develop a program which will allow a waiver if implementation of this annual limit provision would result in a significant decrease in access to benefits or a significant increase in premiums. As we all know, plan sponsors occasionally offer very limited health care coverage to part-time employees or to full-time employees with short service, through so-called "mini-med" programs. On their face, these programs currently provide access to necessary services with annual limits that are far less than those specified in this Interim Final Rule. We expect that the HHS position on this issue will allow mini-med plans to continue to exist at least for the near term. We will keep you informed of developments.

#### Section C: Rescissions (PHSA Section 2712)

1. **Background.** Historically, insurers have retained the right to rescind group and individual health plan coverage for any enrollee upon discovery of a misrepresentation of a material fact, even if the representation was not intentional or made knowingly. Some policies limit the right to rescind by establishing an incontestability time limit, after which the insurer may not rescind coverage based on misrepresentation. Insurers may terminate or cancel group health care coverage or deny claims if the plan sponsor has misrepresented the material facts. State laws frequently require health insurers to guarantee renewals or to continue coverage upon renewal for group health plans absent a failure to pay premium, or evidence of fraud or misrepresentation. Please note: insurers still may cancel coverage at any time under certain other circumstances.
2. **Effective Date.** The Rescission Rule applies to all plans insured or self-insured, whether grandfathered or not, as of the first day of the plan year beginning on or after September 23, 2010.



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3. **The New Rule.** Under Health Reform, rescission is permitted only in the event of fraud or misrepresentation. If the insurer intends to cancel existing coverage based on fraud or misrepresentation, the insurer must provide prior notice and only as permitted under the rules of the network plan (if there is a network involved). The health Reform Law requires that the insurer meet certain standards in its agreements with PPO networks.
4. **HIPAA Non-discrimination Rules.** The Interim Final Rule also prohibits cancellation or denial of health care plan coverage based on an individual's health status. This rule also applies in Health Reform.
5. **Applicability to Group Health Plans.** The new rule clarifies the law by explicitly stating that the prohibition applies not only to rescission of coverage for an individual, but also a rescission of coverage for groups of individuals (i.e. employer-sponsored plans). If the plan sponsor, for example, in applying for group health coverage, intentionally misrepresents a material fact (e.g. they are actually dynamite handlers, not just a service organization), the insurer retains the right to rescind coverage for the entire group.
6. **Definition of Rescission.** For purposes of the Interim Final Rule, a rescission is a cancellation or discontinuance of coverage retroactively. This definition does not include prospective cancellations and does not include cancellation for non-payment of premiums, even though cancellation is typically retroactive to the last day for which premium has been paid (earned).
7. **Advance Notice Required.** In the event that rescission meets the standards set by the Interim Final Rule, the Rule also imposes a 30 day advance notice to individuals and, if applicable, plan sponsors, regardless of whether the coverage is insured or self-insured (i.e. a notice is required from the plan sponsor).

#### Section D: Patient Protections (PHSA Section 2719A)

1. **Background.** For a number of years group health plans have contracted with network providers to obtain volume pricing of provider services. Additionally, group health plans have employed gatekeepers (primary care providers) to help control the use of these services. These primary care providers (PCP) frequently are general practitioners and occasionally internists who belong to the network. Their duties are to direct the use of specialists based on the PCP's knowledge of the patient's medical condition. The Interim Final Rules impose numerous requirements on the use of PCPs. They also address the scope of appropriate emergency services, including cost sharing requirements.
2. **Effective Date.** Patient protections contained in this Section of the Health Reform Law take effect as of the first day of the first plan year beginning on or after September 23, 2010. They do not apply to grandfathered plans.
3. **What the Law Provides.** In brief, group health plans, whether insured or self-insured, must allow enrollees to select a primary care provider from among those available, including pediatricians for children and to obtain OB-GYN services without referral from a PCP. It also requires provider organizations to offer emergency services to non-network patients, without any pre-authorization, that are necessary, without limitations and in the same manner as for network patients and at network pricing.
4. **Choice of a Health Care Professional.** Under plans which require enrollees to choose a PCP, the enrollee must now be able to choose any participating network provider who is available to accept the enrollee. Additionally, the plan/issuer must notify enrollees of their obligation to designate a PCP, including pediatricians for children. The notice must include the general terms of the plan, including pediatric care. Failure to provide the notice of the coverage, including any limitations or exclusions, will result in all related services to be considered covered.



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Plans which provide coverage in-network for OB-GYN services must allow female participants to obtain those services without first obtaining a referral/network authorization. The plan or issuer must provide notice that the plan has no authorization requirement for OB-GYN services. The Interim Final Rule also makes it clear that health care professionals may be any individual authorized under state law to provide OB-GYN services, not just physicians. The Interim Final Rule provides model notice language regarding choice of health care professional. The following model notice must accompany any issuance of a summary plan description or plan benefit summary:

- 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]."*

5. **Emergency Services.** Ambulance service organizations, historically, provide ambulance services to the nearest medical facility without regard to the patient's available health plan coverage. This can result in disparities in cost-sharing and permissible services. Under the Interim Final Rule, the provider must provide emergency services without the need for a pre-authorization whether in network or not. Additionally, providers:

- Must provide necessary services without regard to coverage available under the plan or pursuant to any other plan term, except for coverage exclusions or coordination of benefits rules.
- Must provide these services on the same basis as it would be for network members.
- Must provide these services based on the same cost-sharing (co-pays, co-insurance, etc.) as for network members.

6. **Balance Billing.** Providers, however, may balance bill (excess over what the plan actually pays and the allowance payable for network services) but only if the plan has paid a reasonable amount for the services. The Rule provides a formula applicable to determining what constitutes a "reasonable amount." For purposes of



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capitation plans (network-model HMOs), there is yet another formula in the Interim Final Rule. For a description of these formulas, please consult the Interim Final Rule.

7. **Definition of a Medical Emergency.** For purposes of Health Reform, an emergency medical condition is measured by the potential medical consequences that might reasonably be expected if no treatment were given, as determined by qualified hospital personnel.

**What You Should Do**

1. Study these Rules carefully. Your HIB Account Team is continuing to monitor the legislation as it pertains to your group health plan. There are a few action items, and your HIB Account Team will advise accordingly.
2. At the time each plan (group health policy or self-insured plan) renews, make sure that the plan meets the notice requirements specified in these Interim Final Rules.
3. Contact your group health insurance carrier(s) regarding its implementation table and its capabilities for providing compliance notices to participants and enrollees.
4. Review your plan renewals and weigh the impact of the renewal against the feasibility of maintaining grandfather status.
5. Be prepared for additional rules on each of the topics we have discussed.

To view the Interim Final Rules, go to: <http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf>

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