HUNTON& WILLIAMS

CLIENT ALERT

July 2010

Contacts

Dallas Office
1445 Ross Avenue, Suite 3700
Dallas, Texas 75202-2799
(214) 979-3000

L. Scott Austin*
saustin@hunton.com

Baker R. Rector
brector@hunton.com

Henry Talavera
htalavera@hunton.com

James A. Deets
jdeets@hunton.com

McLean Office
1751 Pinnacle Drive, Suite 1700
McLean, Virginia 22102
(703) 714-7400

David A. Mustone
dmustone@hunton.com

Christina M. Crockett
ccrockett@hunton.com

New York Office
200 Park Avenue
New York, New York 10166-0091
(212) 309-1000

John T. Konther
jkonther@hunton.com

Leslie A. Okinaka
lokinaka@hunton.com

Leslie S. Hansen
lhansen@hunton.com

Richmond Office
951 East Byrd Street
Richmond, Virginia 23219-4074
(804) 788-8200

Mark S. Dray
mdray@hunton.com

J.G. Ritter
jritter@hunton.com

Marc E. Purintun
mpurintun@hunton.com
*Alternate location for
L. Scott Austin:

Atlanta Office
600 Peachtree Street, NE
Suite 4100
Atlanta, Georgia 30308-2216

Health Care Reform — Regulations on Patient Protections Issued

The United States Departments of Health and Human Services ("HHS"), Labor, and the Treasury continue to shed light on the major group health plan reforms mandated under the Patient Protection and Affordable Care Act, as amended (the "Health Care Reform Act"). The agencies have now issued a series of regulations that create what the administration is calling a new "Patient's Bill of Rights." These regulations provide important guidance for group health plans regarding the new rules for

- preexisting conditions,
- annual/lifetime limits, and
- coverage rescissions.

The regulations also provide guidance on required plan participant protections regarding preventive care; the selection of, and access to, primary care providers and OB-GYN specialists; and out-of-network emergency care.

This is one in a series of alerts that address important aspects of the Health Care Reform Act, and the guidance the government has issued to date. For our related alerts, see "Health Care Reform — What Employers Need to Know Now," issued in April 2010, and "Health Care Reform — Grandfathered Plan Regulations Issued," issued in June 2010.

The following is a summary of the more important aspects of recently issued regulations that contain the administration's Patient's Bill of Rights.

Requirements Applicable to All Group Health Plans

The following rules apply to all group health plans, whether insured or self-insured, *including* grandfathered plans. In general, these rules will go into effect for plan years beginning on or after September 23, 2010 — for example, January 1, 2011, for a calendar year plan.

Preexisting Condition Exclusions

The Health Care Reform Act generally prohibits group health plans from denying coverage on account of a preexisting condition. For all participants (and *not* just dependents) who are under age 19, the preexisting condition prohibition applies for plan years beginning on or after September 23, 2010. For all other participants, this prohibition will go into effect in the 2014 plan year.

The regulations provide that a "preexisting condition exclusion" means a limitation or exclusion of benefits

(including a denial of coverage) based on the fact that the condition was present before the effective date of coverage under a group health plan, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. The regulations also clarify that the prohibition applies not only to a coverage/benefit exclusion for a specific condition, but also to a refusal to enroll an individual due to a specific condition. Although many group health plans have already eliminated preexisting condition exclusions, care should be taken to review your plan's current design to confirm that it complies with this prohibition.

Annual/Lifetime Benefit Limits

For plan years beginning on or after September 23, 2010, group health plans may *not* include dollar-denominated lifetime limits on "essential health benefits."[1] In addition, for plan years beginning on or after January 1, 2014, annual limits on the dollar value of benefits for essential health benefits will also be prohibited. In the interim, the regulations provide that a group health plan may apply the following restricted annual limits:

- *$750,000* — for plan years beginning on/after September 23, 2010 (but before September 23, 2011);
- *$1.25 million* — for plan years beginning on/after September 23, 2011 (but before September 23, 2012; and
- *$2 million* — for plan years beginning on/after September 23, 2012 (but before January 1, 2014).

According to the regulations, these annual limits must be applied on an individual-by-individual basis and may not be applied to a family as a whole.[2]

Because these rules focus on dollar-denominated limits, specific limits on treatments (e.g., limits on the number of procedures or visits) are not barred. In addition, as noted above, a group health plan may continue to impose annual or lifetime limits for *nonessential* health benefits. The limitations also do not apply to (i) health care flexible spending accounts, (ii) medical and health savings accounts and (iii) health reimbursement arrangements (HRAs) that either are part of a group health plan that is otherwise compliant or qualify as a "stand-alone" retiree program.

Notice and Re-enrollment Requirements: The regulations provide that group health plans must, prior to the first plan year in which the new rule goes into effect, notify individuals who previously reached a lifetime limit under their group health plan and who are otherwise still eligible for plan coverage, of the elimination of the lifetime maximum. These individuals must also be afforded at least 30 days to re-enroll. This notice and re-enrollment requirement can be achieved as part of the open enrollment process for the applicable plan year.

Rescission

The Health Care Reform Act generally prohibits group health plans from rescinding coverage. The regulations clarify that, for this purpose, a "rescission" is any *retroactive* cancellation or discontinuation of coverage, other than a revocation due to fraud or an intentional misrepresentation of a material fact done/caused by the individual involved (or the person seeking coverage on his or her behalf). Thus, this prohibition does not apply to prospective coverage cancellations; nor does it apply to a retroactive revocation for the failure to pay premiums on a timely basis. At the same time, the regulations also make clear that the rule applies to the rescission of any coverage, be it on an individual, family or group (e.g., employer) basis.

In order to rescind coverage retroactively, a plan must provide the affected individual with 30 days' advance written notice of the rescission. The aim of this notice period is to give the affected individual(s) the opportunity to decide whether to challenge the revocation or to look for other coverage. Unfortunately, it is unclear whether the group health plan must continue to provide coverage in the interim.

The preamble to the regulations explains that this rescission prohibition "builds on already-existing protections." Therefore, if a state law or another federal law provides greater protection with respect to coverage rescissions, the more protective law will apply

[1] The Health Care Reform Act broadly defines "essential health benefits" as including emergency care, hospitalization, maternity and newborn care, preventive and wellness services, prescription drugs, mental health and substance abuse services, pediatric care and certain other basic medical benefits. The preamble to the recently issued regulations provides that until regulations addressing essential health benefits are issued, group health plans must make a good faith effort to apply/follow a reasonable interpretation of this term.

[2] Note, though, that (as the regulations reiterate) a group health plan benefit option will lose grandfathered status if the plan (i) imposes a new annual limit on the dollar value of benefits that did not exist before March 23, 2010 (unless, the new annual limit is at least as high as the plan's existing lifetime limit) or (ii) reduces the dollar value of an existing annual limit.

— which means that there will be no federal preemption in this context.

Requirements Applicable to Non-Grandfathered Group Health Plans Only

The following rules apply to non-grandfathered programs only, and will generally go into effect with plan years beginning on or after September 23, 2010.

Preventive Care

The Health Care Reform Act generally provides that a non-grandfathered plan/option must provide, *without* any cost sharing (i.e., no copays, etc.), certain preventive care, including well-child care, certain immunizations/screenings and other items. The regulations provide that the following four categories of services/items qualify as "preventive" in this context:

1. Items/services that have an "A" or "B" rating under the current recommendations of the U.S. Preventive Services Task Force (which includes, among other things, screenings for breast cancer; heart, vascular and respiratory diseases; HIV; colorectal cancer; high blood pressure; and adult depression);

2. Immunization recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") (to the extent adopted by the CDC);

3. Childhood preventive care screenings recommended by the Health Resources and Services Administration ("HRSA"); and

4. Preventive care/screenings provided under HRSA guidelines (which are not expected to be issued until 2011).

(A list of the services, immunizations and other items that must be treated as preventive care are set out on the HHS website at http://www.healthcare.gov/center/regulations/prevention/recommendations.html.)

The regulations provide that where a group health plan provides coverage through a provider network, the plan will be required to provide the required preventive services *without* cost sharing only in-network. Thus, the plan may either exclude the service or impose cost-sharing requirements for any such care provided out-of-network. The regulations also contain the following special rules for office visits:

- If the *primary* purpose of the visit is preventive care, no charge may be imposed.

- If not, the applicable copayment (or other charge) may be applied to the office visit (if the preventive service is separately tracked) or to the entire bill (if the preventive service is *not* separately tracked).

Patient Protections for Provider Choice and Emergency Care

The regulations also provide patient protections concerning the selection and use of primary care providers ("PCPs") and obstetrical and gynecological ("OB-GYN") care providers and for out-of-network emergency care.

Primary Care Providers: If a group health plan requires participants to designate a PCP, the plan must permit each participant to designate any participating PCP who is available to accept the participant or beneficiary. A similar rule applies with respect to the designation of a pediatrician PCP for a child of a participant or beneficiary. The plan must also provide a notice informing each participant of the terms of the plan regarding the designation of a PCP (including a pediatrician PCP) and of the right of the participant to designate any PCP. The regulations provide a model notice that can be used for this purpose. The notice may be provided in the plan's summary plan description or in the plan's open enrollment package.

OB-GYN Providers: A group health plan that offers OB-GYN coverage may not require a female participant to obtain an authorization or referral by a PCP, the plan or anyone else in order to obtain care from an OB-GYN specialist.[3] Note, however, that this requirement does not

- preclude a plan from requiring the specialist to adhere to the plan's general policies and procedures regarding referrals by the specialist, obtaining prior authorization for treatment or providing services pursuant to an approved treatment plan; or

- mandate the coverage of OB-GYN care, as the regulations specify that nothing in the regulations are to be construed to (i) waive any coverage exclusions under a group health plan for OB-GYN care or (ii) preclude the plan from requiring an OB-GYN provider to

[3] A written notice of this right, similar to the notice described above for PCPs, must also be provided by the plan.

notify the participant's PCP (or plan) of treatment decisions.

Emergency Services: The Health Care Reform Act provides broad patient protections relating to emergency treatment and care by requiring that out-of-network emergency care be provided on essentially the same basis as in-network coverage.[4] Specifically, a group health plan that provides coverage for emergency care must do so

- without the need for any prior authorization, even if the emergency services are provided on an out-of-network basis;
- without regard to whether the health care provider is an in-network provider;
- without imposing, for out-of-network emergency care, any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations applicable to in-network emergency services;
- without regard to any other term or condition of coverage other than the exclusion/coordination of benefits, waiting periods or applicable cost sharing; and
- in compliance with the cost-sharing requirements described below.

The regulations provide complicated rules regarding cost sharing for emergency services. Generally, copayments and coinsurance rates for out-of-network emergency services *cannot* exceed those imposed for in-network emergency services. In addition, while the regulations do not preclude a provider from billing participants for out-of-network costs in excess of what the group health plan pays, they do require that the plan pay for emergency services in an amount equal to the greater of the following three amounts:

- The amount negotiated for the services with in-network providers,[5] less any in-network copayment or coinsurance amount;
- The amount of the benefit as calculated for out-of-network services (e.g., the usual, customary and reasonable amount), but without regard to normal out-of-network cost-sharing requirements and less any in-network copayment or coinsurance amount; or
- The amount that would be paid under Medicare, less any in-network copayment or coinsurance amount.

Lastly, out-of-network deductibles and out-of-pocket maximums may be applied to emergency care, but only to the extent those cost-sharing requirements apply generally to all out-of-network benefits (and not just emergency care).

With the aggressive implementation timing requirements of certain provisions of the Health Care Reform Act, lengthy and complex regulations and other guidance continue to be issued quickly. We welcome the opportunity to assist you in working through this guidance as you deal with the critical issues of health care plan design and related cost, employee relations, and other issues.

[4] In general, emergency services include (i) medical screening(s) to evaluate an emergency medical condition and (ii) further medical examination and treatment, to stabilize the patient incurring the emergency medical condition. An emergency medical condition is generally a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson could, absent immediate medical attention, reasonably expect to result in serious (i) jeopardy of the health of the individual, (ii) impairment to bodily functions or (iii) dysfunction of any bodily organ or part.

[5] If there is more than one amount negotiated with in-network providers for the particular service, the applicable amount is the median of the negotiated amounts.