



June 28, 2010

Patient Protection Regulations and United Methodist Health Plans

Introduction

The Patient Protection and Affordable Care Act (PPACA) adds §9815(a)(1) to the Internal Revenue Code, which makes certain provisions of the Public Health Service Act (PHSA) applicable to insured and self-insured group health plans, *including church plans*. The Department of Health and Human Services (HHS), Department of Labor (DOL) and Internal Revenue Service (IRS)—collectively referred to as the “Departments”—have been issuing regulatory guidance under the PPACA and the PHSA provisions to clarify their meaning and application to plans.

Interim Final Regulations

On June 22, 2010, the Departments released interim final regulations governing the *Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections* (the “Regulations”). The Regulations can be found at www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23983. These Regulations were published in the Federal Register on June 28. The White House also released a press release fact sheet, which refers to these new rules as a “Patient’s Bill of Rights” [www.healthreform.gov/newsroom/new_patients_bill_of_rights.html].

The Regulations establish requirements for group health plans regarding pre-existing condition exclusions, lifetime and annual limits, coverage rescissions and patient protections (including, among others, coverage of emergency services and choice of a primary care physician). Generally, the Regulations apply to coverage starting on or after September 23, 2010 (January 1, 2011 for calendar-year plans). The Regulations adopt a “good faith” compliance standard for enforcement until final regulations are published.

Grandfathered Plans

Section 1251 of the PPACA exempts certain plans existing on March 23, 2010 (i.e., Grandfathered Plans) from many provisions of the PPACA and PHSA. Under the Regulations, Grandfathered Plans must comply with the rules regarding lifetime and annual limits, rescissions, and pre-existing condition exclusions. Grandfathered Plans do not have to comply with the Regulation’s patient protection requirements. You can read more about Grandfathered Plans here: www.gbophb.org/TheWell/Root/HFLX/4079.pdf.

Pre-Existing Condition Exclusions

Under the Regulations, group health plans are prohibited from imposing pre-existing condition exclusions. For individuals under age 19, this rule becomes effective for plan years beginning on or after January 1, 2011 (for calendar-year plans). For other enrollees, the effective date will be January 1, 2014. The prohibition applies to denial of coverage under a group health plan and denial of specific benefits based on the pre-existing condition.

Lifetime and Annual Limits

Group health plans cannot impose lifetime limits on the dollar value of coverage of “essential health benefits.” However, a plan is allowed to impose annual or lifetime dollar limits on covered benefits that are not defined as “essential health benefits.” The PPACA identified broad categories of care considered essential, including: hospitalization, emergency care, ambulatory (outpatient) care, mental health and substance abuse treatment, pediatric services, prescription drugs, and preventive and wellness services. Until the Departments define essential health benefits in future guidance, a reasonable good-faith standard will apply.

Plans can have annual dollar limits on “essential health benefits” no lower than \$750,000 in 2011 (\$1.25 million in 2012 and \$2 million in 2013). The Regulations do not specify whether a plan could have benefit-specific annual limits, such as a \$200,000 limit on maternity care, that add up to the permitted annual limit. Annual limits on essential benefits must be eliminated completely in 2014. According to earlier guidance from the Departments, vision and dental plans are not subject to these Regulations.

Excluding benefits for a particular condition will not be treated as a dollar limit, so plans may choose to not cover certain conditions, provided other federal or state laws (such as the Americans with Disabilities Act) do not prohibit such exclusion. Though not directly addressed in the Regulations, it appears that non-monetary limitations will be permitted, such as a limit on the number of days or visits for treatment.

The Regulations explain that the annual limit does not apply to flexible spending accounts (FSAs), medical savings accounts (MSAs) or health savings accounts (HSAs). Health reimbursement arrangements (HRAs) are not subject to the annual limit when they are integrated with other coverage as part of a group health plan that otherwise complies with lifetime and annual dollar limits. Retiree-only HRAs also are not subject to the annual limits.

Individuals who previously had reached an annual or lifetime limit and lost coverage—but otherwise would be still eligible for coverage—must be given notice and a special right to re-enroll in the plan. Plans must provide this notice before January 1, 2011 and allow an enrollment period of at least 30 days. Notice may be provided in annual enrollment materials.

Rescissions

A “rescission” is a retroactive discontinuance of coverage by a plan. Plans cannot rescind coverage unless an individual intentionally misrepresents facts or commits fraud. Plans must provide at least 30 days advance notice of a rescission, with time to appeal. However, the Regulations do not apply to prospective terminations (such as for loss of eligibility) or to retroactive terminations that are attributable to a covered individual’s failure to pay required premiums or contributions on a timely basis. The Departments intend to issue future guidance on cancellations that are not considered rescissions.

Patient Protections

The Regulations contain new rules applicable only to non-Grandfathered Plans. The Patient Protection provisions address issues affecting participants’ access to providers and the availability of benefits for emergency services.

- Plans must notify employees of their right to designate any network primary care physician who is available to accept the individual as a patient as their primary care physician, and the right to designate any network pediatrician as a child’s primary care physician.
- Plans must notify female participants of their right to obtain services from any network obstetrician/gynecologist (OB/GYN) without a referral.

- Plans cannot require pre-authorization for emergency services (as defined in the Emergency Medical Treatment and Labor Act), limit such services to network providers, or apply any requirement on out-of-network emergency services that is more restrictive than the requirements applicable to in-network emergency services, including cost-sharing requirements. Plans must make a “reasonable” reimbursement for out-of-network emergency care before balance billing is allowed.

The Regulations include model language to meet these notice requirements.

Impact on United Methodist Health Plans

Beginning in 2011, whether or not an annual conference plan remains a Grandfathered Plan, the plan will have to remove its pre-existing condition exclusion on benefits for current and new enrollees who are under age 19. Plans will have to remove the same pre-existing condition exclusions for *all* participants beginning in 2014.

Beginning in 2011, annual conference plans must eliminate current lifetime limits on essential health benefits. Annual conferences will also need to determine if anyone has been terminated from its plan (or had to change from one benefit option to another) on account of reaching a lifetime limit and, if so, allow them a special enrollment opportunity. Annual conference plans’ FSAs and HRAs (provided they are integrated with a plan that otherwise meets the requirements of the Regulations) will not be affected by the Regulations.

The prohibition on rescissions most likely does not significantly impact annual conference plans, as most church plans do not engage in the practice. Annual conferences may need to review their termination and cancellation procedures.

If annual conference plans do not remain Grandfathered Plans, they then must comply with the Patient Protection provisions described above. Compliance will involve some administrative effort (notice requirements), direct financial impact (e.g., lower cost-sharing amounts for out-of-network emergency services), and will affect the network services provided by insurers and claims administrators.

For More Information

If you have questions about the impact of health care reform, please send your inquiry to: healthcarereform@gbophb.org.

You can also find additional information on the Web sites for the Department of Labor’s Employee Benefit Security Administration [www.dol.gov/ebsa/healthreform], the Department of Health and Human Services’ Office of Consumer Information and Insurance Oversight [www.hhs.gov/ociio/regulations/index.html] and at www.healthcare.gov.

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