Health Care Reform 201

Era of

Interim Final Regulations

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Series of Interim Final Regulations

- IFRs on:
  - dependent coverage of adult children
  - grandfathered health plans
  - preexisting condition exclusions, lifetime and annual limits, restrictions on rescission, patient protections
  - preventive health services
  - internal claims and external appeals

Dependent Coverage of Adult Children

- Applies to "group health plans"
- Includes both fully-insured and self-funded plans
- If plan makes dependent coverage of children available, then coverage must be available until age 26.
- Coverage cannot be conditioned on whether child is tax dependent.

Dependent Coverage of Adult Children

- Coverage also cannot be conditioned on:
  - residency ,
  - student status,
  - employment,
  - financial dependency,
  - eligibility for other coverage *, or
  - any combination of these factors.

  * Exception for grandfathered plans

Dependent Coverage of Adult Children

- Coverage may not be conditioned on marital status.
- However, there is no requirement to extend coverage to dependent child's spouse, or the child of dependent child.

Dependent Coverage of Adult Children

- Employers can exclude from an employee's income value of any employer-provided health coverage for the entire year that a child turns 26.
- Example: A child turns 26 in March, but stays on a plan past December 31, the health benefits provided through December 31 can be excluded from income.

Dependent Coverage of Adult Children

- Prior to January 1, 2014, grandfathered plans can exclude an adult child who is under age 26 but is eligible to enroll in other employer-provided coverage.
- Exclusion applies only if other coverage is not group health plan of a parent.

Dependent Coverage of Adult Children

- A plan or issuer must provide adult children under age 26 with an opportunity to enroll.
- Must provide written notice of the opportunity to enroll.
- Enrollment period must continue for at least 30 days and must be provided not later than the first day of the plan year commencing after 9-23-2010.

Dependent Coverage of Adult Children

- Also, coverage must begin no later than first day of the first plan year beginning on or after 9-23-2010, *even if request for enrollment is made after first day of plan year.*

Dependent Coverage of Adult Children

- Notice of eligibility for coverage:
  - can be made to parent on behalf of child, or
  - may be included with other enrollment materials, *provided the statement of eligibility is prominent.*

Dependent Coverage of Adult Children

- Child enrolling under this enrollment right must be treated as a special enrollee.
- Must be offered all of the benefits packages available to similarly situated individuals who did not lose coverage due to dependent status.
- Special enrollees may not be required to pay more for coverage than similarly situated individuals.

Preexisting Condition Exclusions

- January 1, 2014 - preexisting condition exclusions will be prohibited.
- September 23, 2010 – preexisting condition exclusions were prohibited for enrollees under age 19.

Preexisting Condition Exclusions

- Broader than current HIPAA rules
- Prohibits not only exclusion of benefits associated with preexisting condition, but also exclusion from coverage, if exclusion is based on preexisting condition.
- Exclusion of benefits for a condition is not a preexisting condition if exclusion applies regardless of when condition arose.

Lifetime and Annual Limits

- Annual limit restrictions apply differently to account-based plans.
- Example: Restriction on annual limits do not apply to health FSAs, medical savings accounts (MSAs) or health savings accounts (HSAs).
- Special rules for health reimbursement accounts (HRAs).

Lifetime and Annual Limits

- Restrictions on limits apply to “essential health benefits”
- Include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitation services, laboratory services, preventive and wellness services, chronic disease management, pediatric services.

Lifetime and Annual Limits

- Does not prevent plan from excluding all benefits for a condition.
- However, if any benefits are provided for a condition, then requirements of rules apply.

Lifetime and Annual Limits

- Three year phase-in for annual limit restrictions:
  - From 9-23-2010 to 9-23-2011: $750,000
  - From 9-23-2011 to 9-23-2012: $1.25 million
  - From 9-23-2012 to 9-23-2013: $2 million
  - From 1-14-2014, no annual limit.

Lifetime and Annual Limits

- Annual limits apply on an individual basis.
- Overall annual limit applied to families may not be used to deny individual annual limits for a covered individual.
- In applying annual limit, plan may only take into account essential health benefits.

Lifetime and Annual Limits

- Exceptions may be granted by HHS if compliance with interim final regulations would restrict access to benefits or cause significant increase in premiums.

Lifetime and Annual Limits

- For plan years commencing on or after 9-23-2010, lifetime limits for essential health benefits are prohibited.
- Notice requirements for individuals who are eligible for coverage but have reached lifetime limits.

Lifetime and Annual Limits

- Notice of elimination of lifetime limit and opportunity to enroll must be provided to all individuals who are eligible for coverage but who reached lifetime limits.
- Notice and enrollment opportunity must be provided not later than first day of plan year beginning on or after 9-23-2010.

Lifetime and Annual Limits

- Individuals who terminated coverage because of plan limits must be treated as special enrollees.
- Must be given right to enroll in all benefit packages available to similarly situated individuals.

Rescissions

- Group health plan or health insurance issuer may not rescind coverage except in the case of fraud or *intentional* misrepresentation of material fact.
- Builds on existing protections that prohibit plan or health insurance issuer from cancelling, or failing to renew coverage, except for nonpayment of premiums, fraud or intentional misrepresentation, withdrawal of product or issuer, movement outside service area, or if coverage due to association membership, cessation of membership.

Rescissions

- Advance notice of rescission is now required.
- Group health plan or health insurance issuer must provide 30-day advance notice of rescission.
- Advance notice is intended to provide opportunity to contest rescission, or look for alternate coverage.

Patient Protections

- Patient protections only apply to non-grandfathered plans.
- Three requirements relating to choice of health care professionals and emergency services.
- Requirements relating to designation of health care professionals only apply to plans that have network of providers.

Patient Protections

- Primary care provider:
  - If plan or issuer requires or provides for designation of primary care provider, then plan or issuer must permit participant, beneficiary or enrollee to designate any primary care provider in network.
  - Plan or issuer must provide notice to participants of the terms of plan requiring designation of primary care provider.

Patient Protections

- Pediatricians:
  - If plan or issuer requires or provides for designation of pediatrician, then must permit designation of any physician who specializes in pediatrics as a child's primary care provider.
  - Plan or issuer must provide notice of the terms of the plan regarding designation of primary care physician.

Patient Protections

- Obstetrics or gynecology:
  - If plan or issuer requires designation of in-network primary care provider, plan or issuer cannot require authorization or referral by plan or issuer for a female participant who seeks obstetrical or gynecological care provided by an in-network health care professional who specializes in such care.
  - Plan or issuer must inform participants that the plan or issuer may not require authorization or referral.
  - In-network provider must adhere to policies and procedures requiring pre-authorization of treatment, etc.

Patient Protections

- Model language for informing participants of rights regarding designation of primary care provider, pediatrician and provider of obstetrical and gynecological care is included in IFR.
- Notice of these rights must be included in any summary plan description or similar description of benefits.

Patient Protections

- Emergency services:
  - If an plan or issuer provides emergency care services, then plan or issuer may not require prior authorization and must provide coverage without regard to whether emergency services is provided by an in-network or out-of-network provider.
  - Emergency services must be provided without regard to any other term or condition of the plan, except for exclusion or coordination of benefits, permissible waiting periods, or applicable cost-sharing requirements.

Patient Protections

- Emergency services:
  - Cost-sharing requirements for out-of-network services cannot exceed cost-sharing requirements for in-network services.
  - However, out-of network providers can balance bill patients for the difference between the providers' charges and amount collected from the plan/issuer and the patient as a copayment or coinsurance amount.
  - Balance billing only allowed if reasonable amount is paid prior to billing of patient.

Preventive Service Rules

- Apply to non-grandfathered plans.

- Group health plan or health insurance issuer must provide benefits and may not impose cost-sharing requirements for certain types of preventive care.

Preventive Service Rules

- Preventive care services include:
  - Evidence-based items or services that have in effect a rating of A or B in the current recommendations of U.S. Preventive Services Task Force ("Task Force")
  - Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC.

Preventive Service Rules

- Preventive care services include:
  - For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA")
  - For women, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA.

Preventive Service Rules

The complete list of recommendations and guidelines for preventive care can be found at www.HealthCare.gov/center/regulations/prevention.

Preventive Service Rules

Cost-sharing requirements where preventive services are provided in office visit are addressed by examples in IFR.

There are different rules where the preventive care is billed separately, not billed separately, and where primary purpose of office visit was not preventive care.

Next Session

- Internal Claims and External Appeals