

Explaining Health Care Reform: “Patients’ Bill of Rights” Regulations

Louisiana Business Group on Health
Audio Workshop
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Presented by:

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Insurance Reforms

Requirement	Applicability
<p>No pre-existing condition exclusions on enrollees under age 19 for plan years beginning on or after September 23, 2010</p> <p>No pre-existing condition exclusions on any enrollee as of January 1, 2014</p>	<p>Grandfathered Plans</p> <p>New Plans</p>
<p>No lifetime limits on the dollar value of essential health benefits</p>	<p>Grandfathered Plans</p> <p>New Plans</p>
<p>Only “restricted annual limits” on the dollar value of essential health benefits until 2014</p> <p>No annual limits on essential health benefits as of January 1, 2014</p>	<p>Grandfathered Plans</p> <p>New Plans</p>



Insurance Reforms

Requirement	Applicability
No rescissions other than in cases of fraud or misrepresentation	Grandfathered Plans New Plans
Patient Protections (e.g. choice of health care provider and coverage of emergency services)	New Plans

Interim final rules on these requirements were issued on June 22, 2010. The new rules are effective for plan years beginning on or after September 23, 2010



**PRE-EXISTING CONDITION
EXCLUSIONS
AND
LIFETIME AND ANNUAL LIMITS**



Pre-existing Condition Exclusions

- A pre-existing condition exclusion is a limitation or exclusion of benefits based on the fact that the condition was present before the effective date of coverage under a group health plan or health insurance policy, regardless of whether medical advice, diagnosis, care, or treatment was recommended or received.
- A pre-existing condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of the person's health status before the effective date of coverage.



Lifetime and Annual Limits

- No lifetime or annual limits may be placed on the dollar value of essential health benefits.
- Annual or lifetime limits may be placed on the dollar value of specific covered benefits that are *not* essential health benefits, provided such limits are otherwise permitted under state and federal law.
- The exclusion of all benefits for a particular condition is not considered to be a lifetime or annual limit.



Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative services
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care



Lifetime and Annual Limits

- Annual limits on the dollar value of essential benefits are permissible if such limits comply with the amounts set forth in the table.
- Prior to January 1, 2014, HHS may establish a program which allows plan sponsors to seek waiver of the restricted annual limits if compliance would result in a significant decrease in access to benefits or a significant increase in premiums.

Applicable Plan Year (for calendar year plans)	Permissible Limit
2011	\$ 750,000
2012	\$ 1,250,000
2013	\$ 2,000,000



Lifetime and Annual Limits

- The regulations contain a transitional rule for individuals whose coverage or benefits ended by reason of reaching a lifetime limit.
- Such individuals must be given the opportunity to re-enroll in the plan.
- Individuals must be given at least 30 days to enroll.
- A plan must give individuals written notice that the lifetime limit on the dollar value of all benefits no longer applies, and that they are eligible for benefits under the plan.
 - Calendar year plans must provide notice on or before January 1, 2011.
 - Notice may be included in other enrollment materials, provided the statement is prominent.
 - Notice may be provided to an employee on behalf of his or her dependent.



Rescissions

- Rescission is defined as the cancellation or discontinuance of coverage that has retroactive effect.
- A group health plan must provide at least 30 days advance written notice to each participant before coverage may be rescinded.
- Coverage may only be rescinded if an individual commits fraud or makes an “*intentional* misrepresentation of material fact.”



Rescissions

Example 1: Employee A completes a medical questionnaire as part of group health plan enrollment. A inadvertently fails to disclose that she visited a psychologist on two occasions six years ago. A is later diagnosed with breast cancer and seeks benefits under the plan. At the same time, the plan learns of A's psychological treatment.

Conclusion: The plan cannot rescind A's coverage based on her inadvertent failure to disclose information about prior treatment.



Rescissions

Example 2: An employer's plan provides coverage to full-time employees, which is defined as individuals who work at least 30 hours a week. Employee B is covered under the plan. The employer reassigns B to a part-time position. Under the terms of the plan, B is no longer eligible for coverage. The plan mistakenly continues to deduct premiums from B's wages and pay claims. Upon discovery of this error, the plan rescinds B's coverage effective as of the date B became a part-time employee.

Conclusion: The plan may not rescind B's coverage because there was no fraud or intentional misrepresentation. The plan may cancel B's coverage prospectively, subject to other applicable state and federal laws.





PATIENT PROTECTIONS

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Choice of Health Care Professional

- A plan or insurer that requires a participant or beneficiary to designate a primary care provider must permit:
 - a covered person to designate any participating primary care provider who is available to accept the participant or beneficiary;
 - a covered person to designate a pediatrician who is a participating provider and available to accept a child as that child's primary care provider; and
 - a covered female to receive obstetrical or gynecological care from a participating provider who specializes in obstetrics and gynecology without prior authorization or referral.



Choice of Health Care Professional

- A plan or insurer must give participants and beneficiaries notice of the rules regarding designation of primary care providers, pediatricians as primary care providers, and access to obstetrical and gynecological care.
- Notice must be included when a plan or insurer provides a participant with a summary plan description or similar description of benefits under the plan.



Coverage of Emergency Services

- A plan or insurer that provides benefits for services in an emergency department of a hospital must provide coverage (a) without the need for any prior authorization; and (b) whether the services are provided in-network or out-of-network.
- A plan or insurer with a network of emergency service providers may not impose any administrative requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network providers.
- Any copayment or coinsurance imposed on out-of-network emergency services cannot exceed the in-network cost-sharing levels.



Coverage of Emergency Services

- A plan or insurer will satisfy the cost-sharing requirements for out-of-network providers if benefits are provided in an amount equal to the greatest of the following:
 - the amount negotiated with in-network providers;
 - the amount calculated under the plan or insurer’s normal out-of-network method (such as the usual, customary, and reasonable amount), substituting in-network cost-sharing provisions for out-of-network provisions; or
 - the amount Medicare would have paid.
- A deductible or out-of-pocket maximum may be imposed on emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.



Coverage of Emergency Services

Example 1: A group health plan imposes a 25% coinsurance requirement on individuals who receive emergency services, whether provided in-network or out-of-network. The coinsurance rate is reduced to 15% if the participant notifies the plan within two business days of receiving emergency treatment.

Conclusion: Even though participants are required to notify the plan to receive a reduction in the coinsurance rate, the plan complies with the rules because it does not require prior authorization for emergency services.



Coverage of Emergency Services

Example 2: A plan imposes a \$40 copayment on emergency services without preauthorization, whether provided in-network or out-of-network. If the services are authorized in advance, the copayment is waived.

Conclusion: Because the plan requires prior authorization for emergency services, it does not comply with the requirements for coverage of emergency services.



Coverage of Emergency Services

Example 3: A plan covers emergency services rendered by out-of-network providers. The plan has agreements with in-network providers to perform a certain emergency service for a stated amount. Among all the providers of the service: one has agreed to accept \$85, two have agreed to accept \$100, two have agreed to accept \$110, three have agreed to accept \$120, and one has agreed to accept \$150. The plan agrees to pay providers 80% of the agreed amount.

Conclusion: The median amount among those agreed to for the emergency service is \$110. Therefore, the plan must pay \$88 ($\$110 \times 80\%$) to meet the requirements for coverage of emergency services.



Coverage of Emergency Services

Example 4: A plan covers emergency services rendered by out-of-network providers. The plan has agreements with in-network providers to perform a certain emergency service for a stated amount. The median amount among those agreed to for the emergency service is **\$115**. Under the provider agreements, the plan agrees to pay providers **80%** of the agreed amount.

A participant receives the emergency service from an out-of-network provider who charges **\$125** for the service. The plan generally pays **50%** of the reasonable amount charged by an out-of-network provider for medical services. The reasonable amount for a particular service is determined by evaluating the charges by all providers in a geographic area. For this particular service, the reasonable amount is calculated to be **\$116**. The amount that would be paid under Medicare for the service is **\$80**.



Coverage of Emergency Services

Conclusion: The plan must pay the highest of the following:

- **The amount negotiated with in-network providers, without regard to coinsurance amounts: \$92 ($\$115 \times 80\%$)**
- **The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services, excluding coinsurance amounts: \$92.80 ($\$116 \times 80\%$)**
- **The amount paid for the service under Medicare: \$80**



Coverage of Emergency Services

Example 5: A plan imposes a \$250 deductible for all services received in-network and a \$500 deductible for out-of-network services. A participant submits a claim for \$260 for emergency services received out-of-network.

Conclusion: The participant has not satisfied the deductible which applies to all health care received out-of-network; therefore, the plan is not required to pay the claim. However, the amount paid by the participant is applied to his deductible.



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