

Health Care Reform Update

The Departments Issue Further Guidance on Health Care Reform

The Departments of the Treasury, Labor and Health and Human Services (collectively, the Departments) issued final interim regulations addressing many of the new consumer protections contained in the Patient Protection and Affordable Care Act (PPACA),¹ including the restrictions on lifetime and annual limits on “essential benefits.”

The regulations are effective August 27, 2010 and generally apply to plan years beginning on or after September 23, 2010 (unless otherwise noted in this summary).

This release discusses the regulations as they pertain to an employer-sponsored group health plan. Specifically, it addresses guidance that applies to all group health plans (grandfathered and non-grandfathered) and specific patient protections that apply to non-grandfathered group health plans.

Briefly, for all group health plans, the regulations:

- Fail to define what constitutes an *essential benefit* beyond what is contained in the statute, but allow for good faith interpretation until further guidance is issued, and provide a schedule of permitted annual limits that can be imposed on *essential benefits* prior to January 1, 2014;
- Suggest that a waiver program may be available for limited medical plans (“mini-meds”) to provide relief from the prescribed permitted annual limits;
- Require a notification and re-enrollment opportunity for individuals who previously exhausted lifetime limitations under the group health plan;
- Clarify the pre-existing condition exclusion prohibition, including the various effective dates; and
- Provide a definition of a *rescission of coverage* and impose an advanced notification requirement on plans that rescind coverage.

For non-grandfathered group health plans, the regulations:

- Clarify the rules for choosing a health care provider (in-network doctors, pediatricians and OB/GYNs) for group health plan that require a primary care physician designation, including new notification obligations; and
- Provide a definition of *emergency services* and additional guidance on the requirement that a plan may not impose prior authorizations for emergency services and must treat emergency services as covered in-network even if received out-of-network.

The following provides further detail on these requirements.

¹ As amended by the *Health Care and Education Affordability Reconciliation Act of 2010*, enacted March 30, 2010.

LIFETIME AND ANNUAL LIMITATIONS

Generally, a group health plan will be prohibited from establishing any lifetime or annual limitation on *essential benefits*. However, prior to January 1, 2014, a group health plan may apply “restricted annual limits” on *essential benefits*, provided such limits are no less than the following amounts:

- For plan years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000;
- For plan year beginning on or after September 23, 2011, but before September 23, 2012, \$1,250,000; and
- For plan years beginning on or after September 23, 2012, but before January 1, 2014, \$2,000,000.

Example: Employer Q maintains a group health plan with a plan year beginning October 1 and ending September 30. For the plan year beginning on October 1, 2009, Q has an annual limit on the dollar value of all benefits of \$500,000.

In this example, Q must raise the annual limit on the dollar value of essential health benefits to at least \$750,000 for the plan year beginning October 1, 2010. For the plan year beginning October 1, 2011, Q must raise the annual limit to at least \$1.25 million. For the plan year beginning October 1, 2012, Q must raise the annual limit to at least \$2 million. Q may also impose a restricted annual limit of \$2 million for the plan year beginning October 1, 2013. After the conclusion of that plan year, Q cannot impose an overall annual limit.²

These limits are minimum thresholds and the plan (or state law in an insured arrangement) may be more generous. For example, a plan could impose a \$1,000,000 annual limitation in 2010 as opposed to the \$750,000 limitation.

Further, nothing in the regulations prohibits a plan from imposing an annual and/or lifetime dollar limit on *non-essential benefits*. However, it may be difficult to determine what benefits constitute *essential benefits* without a clear definition.

What are Essential Benefits?

The regulations do not define the term *essential benefits*. Instead, the rule relies on the definition that is contained in the statute which includes at least the following general categories and the items and services covered within the categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

² Raising this dollar limit to comply with Federal Law should not affect the grandfathered status of a plan.

For plan years that begin before the issuance of regulations defining *essential health benefits*, the Departments will take into account good faith efforts to comply with a reasonable interpretation of this term for enforcement purposes. The guidance makes clear that a plan must apply the definition of *essential health benefits* consistently (e.g., plan could not both apply a lifetime limit to a particular benefit – thus taking the position that it was not an essential health benefit – and at the same time treat that particular benefit as an essential health benefit for purposes of applying the restricted annual limit). The Departments indicate that future guidance is expected to clarify this definition.

Account Based Plans

Generally, the prohibition on annual limitations will not apply to health Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs).

Health Reimbursement Arrangements (HRAs) that are retiree-only programs or integrated as part of an active employee group health plan that otherwise comply with the general prohibition on annual and lifetime limitations will be deemed to comply with the regulations. However, it is unclear how the regulations will treat a non-retiree, standalone HRA. The Departments are seeking comments regarding the application of annual limits on this type of arrangement. More guidance on this issue is expected.

Relief for Limited Medical Plans

For plan years beginning before January 1, 2014, the Secretary of Health and Human Services (HHS) may establish a program under which the requirements relating to annual limits **may be waived** for a group health plan with an annual dollar limit on benefits below the permitted limits. Such a waiver may be available if compliance with the prescribed limits would result in a significant decrease in access to benefits under the plan or would significantly increase premiums for the plan.

This waiver program may benefit certain limited medical plans or “mini-med” plans, which generally have annual limitations capped well below the permitted limits identified in the regulations. More guidance on a waiver program is expected in the coming weeks, including when HHS intends to make such a program available, and the details of any such program including what plans are eligible and how to apply for relief.

Notification and Enrollment

A special transition rule applies to individuals whose coverage under the group health plan ended because they reached the lifetime limit. Effective on the first day of the first plan year that begins on or after September 23, 2010, these individuals become eligible for benefits that are not subject to a lifetime limit.

Individuals must be provided with a written notice that the lifetime limit on the dollar value of benefits no longer applies, and that the individual (if covered) is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan, the plan must give the individual at least a 30-day re-enrollment opportunity (including written notice and opportunity to enroll). The notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

Notice can be provided to an employee on behalf of a dependent. Also, notices may be provided in other enrollment materials that the plan provides as long as the notice is prominent. A model notice is available.

An individual enrolling in the group health plan following the expiration of a lifetime limitation must be treated as a special enrollee. Therefore, the individual (and, in the case where the individual was not the employee/participant once enrolled in the plan, the employee/participant through whom the coverage is otherwise made available) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage under the group health plan. Individuals enrolling under this special provision cannot be required to pay more for coverage than similarly situated individuals.

Example 1: Employer Y maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For plan years beginning before September 23, 2010, the plan has a lifetime limit on the dollar value of all benefits. Brianna, an employee of Y, was enrolled in Y's group health plan at the beginning of the 2008 plan year. On June 10, 2008, Brianna incurred a claim for benefits that exceeded the lifetime limit under Y's plan and ceased to be enrolled in the plan. Brianna is still eligible for coverage under Y's group health plan. On or before January 1, 2011, Y's group health plan gives Brianna written notice informing her that the lifetime limit on the dollar value of all benefits no longer applies, that individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to reenroll in the plan, and that individuals can request such enrollment through February 1, 2011 with enrollment effective retroactively to January 1, 2011.

In this example, the plan has complied with the requirements by providing a timely written notice and enrollment opportunity to Brianna that lasts at least 30 days.

Example 2: Employer Z maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan has a lifetime limit on the dollar value of all benefits. Dan, an employee of Z, and Evan, Dan's child, were enrolled in family coverage under Z's group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, Evan incurred a claim for benefits that exceeded the lifetime limit under Z's plan. Dan dropped family coverage but remains an employee of Z and is still eligible for coverage under Z's group health plan.

In this example, not later than October 1, 2010, the plan must provide Dan and Evan an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective no later than October 1, 2010.

Impact on Grandfathered Plans

Generally, changes made to comply with the Federal Law should not affect a group health plan's grandfathered status. However, it is possible that other changes made to the annual dollar limitation could cause a group health plan to lose its grandfathered status.³

Example: Employer Q maintains a group health plan with a plan year beginning October 1 and ending September 30. For the plan year beginning on October 1, 2009, Q has an annual limit on the dollar value of all benefits of \$1 million and Q lowers the annual limit for the plan year beginning October 1, 2010 to \$750,000.

In this example, Q complies with the annual limit requirements. However, Q's choice to lower its annual limit means that the group health plan will cease to be a grandfathered health plan.

³ These changes include:

- Implementing an annual or lifetime limit when the plan or coverage did not impose such limitations as of March 23, 2010;
- When a plan that, as of March 23, 2010, did not have an overall annual limitation on the dollar value of benefits but imposed an overall lifetime limitation, adopts an annual limit at a dollar value lower than the lifetime limit in effect as of March 23, 2010; and
- When a plan that imposed an overall annual limit on the dollar value of benefits, as of March 23, 2010, decreases the dollar value of the limit.

PRE-EXISTING CONDITION EXCLUSIONS

Effective for plan years beginning on or after September 23, 2010, a group health plan may not impose a *pre-existing condition exclusion*⁴ on enrollees who are under 19 years of age.

Example: Frank commences employment and enrolls Frank and Frank's 16-year old child in the group health plan maintained by Frank's employer, with a first day of coverage of October 15, 2010. Frank's child had a significant break in coverage because of a lapse of more than 63 days without creditable coverage immediately prior to enrolling in the plan. Frank's child was treated for asthma within the six-month period prior to the enrollment date and the plan imposes a 12-month pre-existing condition exclusion for coverage of asthma. The next plan year begins on January 1, 2011.

In this example, the plan year beginning January 1, 2011 is the first plan year of the group health plan beginning on or after September 23, 2010. Thus, beginning on January 1, 2011, because the child is under 19 years of age, the plan cannot impose a pre-existing condition exclusion with respect to the child's asthma, regardless of the fact that the pre-existing condition exclusion was imposed by the plan before the applicability date of this provision.

Effective for plan years beginning on or after January 1, 2014, all pre-existing condition exclusions will be prohibited.

RESCISSIONS OF COVERAGE

A group health plan must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A group health plan, or a health insurance issuer, must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded, regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group.

A *rescission of coverage* means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Example: An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Bob has coverage under the plan as a full-time employee. The employer reassigns Bob to a part-time position. Under the terms of the plan, Bob is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from Bob

⁴ A *pre-existing 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 (or if coverage is denied, the date of the denial) under a group health plan whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. 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 information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

and paying claims submitted by Bob. After a routine audit, the plan discovers that Bob no longer works at least 30 hours per week. The plan rescinds Bob's coverage effective as of the date that Bob changed from a full-time employee to a part-time employee.

In this example, the plan cannot rescind Bob's coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for Bob prospectively, subject to other applicable Federal and State laws.

PATIENT PROTECTIONS THAT APPLY TO NON-GRANDFATHERED PLANS

The following requirements only apply if a group health plan is not a grandfathered plan.

Choice of Health Care Provider

Generally, if a group health plan requires or provides for designation by a participant or beneficiary of a participating primary care provider (PCP), the plan must permit each participant or beneficiary to designate any available PCP. In the case of a beneficiary who is a child, a plan must allow the participant or beneficiary to designate a physician who specializes in pediatrics as the child's PCP, assuming the pediatrician is available to accept the child as a patient.

Further, a plan may not require an authorization or referral by the plan, issuer or other individual (including a PCP) in order for a female participant or beneficiary to seek coverage of obstetrical or gynecological care (OB/GYN) provided by a participating health care professional.

With respect to all of these requirements, notice must be provided to each participant or beneficiary regarding the designation of a PCP and of the following rights:

- That any participating PCP who is available to accept a participant or beneficiary can be designated;
- That any participating physician who specializes in pediatrics may be designated a PCP for a child; and
- That the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in the field.

This notice must be included whenever the plan provides a participant with a summary plan description (SPD) or other similar description of benefits. Model language is available.

Coverage for Emergency Services

Generally, a group health plan must provide coverage for emergency services consistent with the following:

- Without the need for any prior authorization determination, even if services are provided out-of-network;
- Without regards to whether the health care provider furnishing emergency services is a participating network provider;
- If the emergency services are provided out-of-network, the plan may not impose any administrative requirement or limitation on coverage that is more restrictive than what is imposed on emergency services received in-network;
- If the emergency services are provided out-of-network, the plan will need to comply with a certain cost-sharing requirements,⁵ and
- Without regards to any other term or condition of coverage other than coordination of benefits, permitted waiting periods and applicable cost sharing.

⁵ The specific cost-sharing requirements are discussed in detail in the regulations, including examples.

*Emergency services*⁶ generally means with respect to an *emergency medical condition*:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services that are routinely available to evaluate an emergency medical condition; and
- Any further medical examination or treatment, to the extent it is within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

An *emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that:

- Places the health of the individual (including in the case of a pregnancy, the health of the woman and unborn child) in serious jeopardy;
- Causes a serious impairment to bodily functions; or
- Causes serious dysfunction to any bodily organ or part.

WHAT SHOULD PLAN SPONSORS DO?

- Review the terms of your plans to determine whether changes are needed to comply with these new requirements effective with the first plan year that begins on or after September 23, 2010.
- If your plan currently imposes annual limits, ensure your plan will comply with the approved minimum thresholds for such limitations on *essential benefits*.
- If offering limited medical plans, await further guidance to determine whether your plan will be eligible for a waiver from the annual limitation requirement. It is expected the government will establish an application and approval process for a plan to qualify for relief.
- Ensure proper notifications are provided to individuals who become eligible for coverage due to the removal of lifetime limits.
- Review processes and procedures in place for revoking coverage when an individual has not engaged in fraud or an intentional misrepresentation of fact (e.g., in the case of mistake), and ensure such procedures do not violate the prohibition on rescissions.
- If rescinding coverage, ensure proper notification is provided.
- If your plan is a non-grandfathered group health plan, ensure compliance with the following:
 - If a PCP designation is required, that it conforms to the new rules and that proper notification is provided to participants.
 - Ensure that emergency services covered by your plans comply with the new requirements for out-of-network emergency services.
- Continue to monitor guidance as it develops.

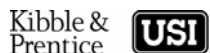
For a copy of the regulations, visit <http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf>.

For a Fact Sheet, visit http://www.healthreform.gov/newsroom/new_patients_bill_of_rights.html.

⁶ The regulations define this term in reference to Section 1867 of the Social Security Act; 42 U.S.C. 1395dd.

Model Notices are available:

- **Model Notice on Patient Protections, available at <http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc>.**
- **Model Notice on Lifetime Limits No Longer Applying and Enrollment Opportunity, available at <http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc>.**



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601 Union St
Suite 1000
Seattle, WA 98101
206.441.6300
kpc.com

700 NE Multnomah
Suite 1300
Portland, OR 97232
503.224.8390
usinw.usi.biz

1255 Treat Boulevard
Suite 300
Walnut Creek, CA 94597
925.472.6770
usi.biz

2021 W March Lane
3rd Floor
Stockton, CA 95207
209.957.6800
usi.biz

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