



REYNOLDS & REYNOLDS INC.

Patient's Bill of Rights

On June 22, 2010, the Departments of Health and Human Services, Labor and Treasury, issued interim final regulations regarding what is being termed the "Patient's Bill of Rights" under the Patient Protection and Affordable Care Act (PPACA). The guidance addresses preexisting condition exclusions, lifetime and annual dollar limits and retroactive rescissions. These regulations will take effect starting on or after September 23, 2010 for most plans. Calendar year plans will be subject to the rules on January 1, 2011.

Provisions that apply to **all** health plans, **including** grandfathered health plans :

- ✓ Prohibits preexisting condition exclusions, including a denial of coverage, on enrollees under age 19 (this does not apply to individual policies that are grandfathered)
- ✓ Prohibits lifetime limits on the dollar amount of "essential health benefits"
- ✓ Restricts annual dollar limits on "essential health benefits"(does not apply to individual policies that are grandfathered, health flexible spending accounts, health savings accounts or medical savings accounts)
 - September 23, 2010 - Annual limits no lower than \$750,000
 - September 23, 2011 – Annual limits no lower than \$1.25 million
 - September 23, 2012 – Annual limits no lower than \$2 million
 - January 1, 2014 – No annual dollar limits allowed
- ✓ Prohibits retroactive rescissions of coverage except in cases of fraud or an intentional misrepresentation of material facts

Provisions that apply to health plans, **except** grandfathered health plans:

- ✓ Allows health plan members to designate any available participating primary care provider (PCP) as their provider
- ✓ Allows health plan members to designate a participating pediatrician as their child's primary care provider
- ✓ Prohibits the requirement of a referral for obstetrical or gynecological (OB-GYN) care
- ✓ Prohibits charging a higher cost (copayments or coinsurance) or requiring a referral or prior approval for emergency services that are obtained out of network

Employer requirements:

- ✓ Self-insured and insured group health plans are required to provide written notice to individuals, whose coverage ended due to reaching a lifetime limit on the dollar value of all benefits, that this lifetime limit no longer applies and that the individual is eligible for benefits under the plan.
 - The notice and time period to enroll must be provided the first day of the first plan year beginning on or after September 23, 2010.
 - The notice may be provided to an employee on behalf of the employee's dependent.

- The notice may be included with other enrollment material that a plan distributes to employees, provided the statement is prominent.
 - The individual must be given at least 30 days to enroll.
 - Coverage must take effect no later than the first day of the first plan year beginning on or after September 23, 2010.
 - The individual enrolling under this opportunity must be treated as if the individual is a Special Enrollee meaning that they must be offered all the benefit packages available to similarly situated individuals who did not lose coverage due to reaching the lifetime limit.
- ✓ Health plans and issuers that require or allow for the designation of a PCP by the enrollees must provide notice to the enrollees stating the terms of the plan in regard to the designation of the PCP or pediatrician, as well as the right to directly see a participating OB-GYN.
- The notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.
 - The notice must be provided whenever the plan provides a participant with a summary plan description or other similar description of the benefits under the plan.

Model notices can be found at: <http://www.dol.gov/ebsa/healthreform/>

Items that are still unclear:

- ✓ What is the definition of “essential health benefits”? The statute provides that “essential health benefits” include at least the following general categories (ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services). Until final regulations defining “essential health benefits” are issued, compliance within good faith with “reasonable interpretation” will be allowed.
- ✓ Are non-dollar limits such as the number of covered services or limits on the frequency of services allowed?
- ✓ How will the annual dollar limit restrictions affect limited benefit or “mini-med” plans? For plan years beginning prior to 2014, there might be a waiver program available for these types of plans if compliance with the restricted annual limits would result in a significant decrease in access to benefits or would significantly increase premiums for the plan. If the waiver program is not implemented, employees covered under a limited benefit or “mini-med” plan could be negatively impacted if the plan has to significantly raise premiums to cover the increase in benefit annual limits.

Things to consider:

- ✓ The delivery requirements for the required notices under health care reform are different so it is important to review the rules for providing them.
- ✓ Carriers might dictate the timing and process of the distribution of the required notices.

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