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UPDATE
Employee Benefits and Compensation

JULY 2010

New "Patient's Bill of Rights" Issued under the Patient Protection and Affordable Care Act

On June 22, 2010, the Internal Revenue Service (IRS), the Department of Labor's Employee Benefits Security Administration (EBSA), and the Department of Health and Human Services (HHS) issued interim final rules regarding preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, and patient protections under the Patient Protection and Affordable Care Act. The interim final rules were published in the Federal Register on June 28, 2010, and will generally apply to health plans for plan years commencing on or after September 23, 2010.

BACKGROUND

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (together, the "Act"), implements sweeping changes to the American health care system. The new rules issued on June 22, popularly referred to as the "Patient's Bill of Rights," include a host of new mandates for employer-sponsored group health plans, both insured and self-insured, with some exceptions for plans that were in effect as of March 23, 2010, and meet certain requirements (Grandfathered Health Plans).

PREEXISTING CONDITION EXCLUSIONS

Currently, the Health Insurance Portability and Accountability Act (HIPAA) permits limited coverage exclusions in certain circumstances on the basis of a preexisting condition. Under the new rules, group health plans may not impose any preexisting condition exclusions, such as benefit limitations and coverage denials. The prohibition on preexisting condition exclusions applies to enrollees under age 19 for plan years beginning on or after September 23, 2010. For all other enrollees, the prohibition does not apply until the first plan year beginning on or after January 1, 2014. The prohibition on preexisting condition exclusions applies to both grandfathered and nongrandfathered plans.

LIFETIME AND ANNUAL DOLLAR LIMITS ON BENEFITS

The new rules prohibit group health plans from imposing lifetime or annual dollar limits on the

amount of "essential health benefits" individual participants receive for plan years beginning on or after September 23, 2010. The annual limit restrictions apply differently to certain account-based plans as follows:

- Health Flexible Spending Arrangements are limited to $2,500 (indexed for inflation) per year, beginning with taxable years in 2013.
- Medical Savings Accounts and Health Savings Accounts are generally not treated as group health plans and are subject to other statutory limitations.
- Health Reimbursement Arrangements are allowed to impose lifetime and annual limits if they are retiree-only or integrated with group health plans that do not impose lifetime or annual limits.

Prior to January 1, 2014, group health plans are permitted to impose "restricted annual limits" on an individual basis. The minimum limit applies to the aggregate amount of essential health benefits and will rise as follows:

- $750,000 for plan years that begin on or after September 23, 2010
- $1.25 million for plan years that begin on or after September 23, 2011
- $2 million for plan years that begin on or after September 23, 2012
- No limits may be applied for plan years that begin on or after January 1, 2014

Individuals who have already reached a lifetime limit must be notified that the limit no longer applies and be given a 30-day opportunity to reenroll in the plan. The annual and lifetime limit rules apply to both grandfathered and nongrandfathered plans.

RESTRICTIONS ON RESCISSIONS

The new rules further prohibit group health plans from rescinding coverage for individuals or groups unless there is fraud or an intentional misrepresentation of a material fact. When rescission is permitted, group health plans must provide 30 days notice to affected individuals or groups. The notice requirement is intended to allow individuals to appeal the decision or to seek alternative coverage. The restrictions on coverage rescissions apply to both grandfathered and nongrandfathered plans and are effective for plan years beginning on or after September 23, 2010.

PATIENT PROTECTIONS

The rules also address a series of patient protections applicable to group health plans relating to a participant's choice of health care provider and additional requirements relating to benefits for emergency services. Specifically, plan participants may choose their primary care physician or pediatrician and may obtain obstetrical or gynecological care without a referral. Furthermore, to make emergency services more accessible, group health plans may no longer charge higher cost-sharing amounts for out-of-network emergency services. The patient protection provisions apply only to nongrandfathered plans and are effective for plan years beginning on or after September 23, 2010.

Employers and plan administrators may wish to review these regulations to determine how their

obligations will change under the Act. To receive more information on the new "Patient's Bill of Rights," and its effects on your benefit programs, please contact one of the following attorneys:

Bruce B. Barth	Cynthia Christie	Virginia Spiess	Jean Tomasco
(860) 275-8267	(860) 275-8259	(860) 275-8291	(860) 275-8323
bbarth@rc.com	cchristie@rc.com	vspiess@rc.com	jtomasco@rc.com

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