SITZMANN ▪ MORRIS ▪ LAVIS

TO: Clients of Sitzmann Morris & Lavis Inc.

RE: Interim Final Regulations on "Patient's Bill of Rights"; Dependent Coverage and Lifetime Limit Model Notices

Background: The Patient Protection and Affordable Care Act (PPACA) contain a set of provisions referred to as the Patient's Bill of Rights. These include the following provisions: pre-existing condition exclusions, annual and lifetime limits, rescission of coverage and patient protection. PPACA also includes a provision for coverage of dependents to age 26. All of these provisions take effect at least in part for plan years beginning on or after September 23, 2010.

In May, interim final regulations were published providing guidance on the dependent coverage provision. (See *SML Update*, Dependent Coverage Interim Final Rules, dated May 11, 2010). The regulations require a plan to provide a written notice to all eligible participants.

On June 28, 2010, interim final regulations were published providing guidance on the "Patient's Bill of Rights" provisions. I will outline the regulations below.

On July 7, 2010, the Department of Labor (DOL) released two model notices to help plan sponsors comply with the notice requirements under the dependent coverage to 26 and lifetime limit provisions. A third model notice was also released for the patient protection provision.

Interim Final Regulations:
To view the Interim Final Rules, go to: http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf

Pre-existing condition exclusions

Effective date. This provision has two parts with different effective dates.

- Pre-existing conditions limitations and exclusions will no longer apply to dependent children under the age of 19, as of the first day of the plan year beginning on or after September 23, 2010 for all group health plans, insured or self insured, whether grandfathered or not.
- Pre-existing condition limitations and exclusions are prohibited for all enrollees for plan years beginning on or after January 1, 2014.

The regulations clarified the definition of a pre-existing condition. The Health Insurance Portability and Accountability Act (HIPAA), for purposes of its waiver for a pre-existing condition, defines a pre-existing condition as a limitation or exclusion of benefits related to a

condition if that condition was present before enrollment in the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received prior to enrollment. To remove any ambiguity for purposes of Health Reform, Congress expanded this definition. The PPACA prohibits not just an exclusion of coverage for a specific pre-existing condition but also prohibits a complete exclusion of health plan coverage if there is a pre-existing condition. The HIPAA rule that an exclusion of benefits for a particular condition under a plan or policy without regard to when the condition arose remains in effect.

Lifetime and Annual Limits

Effective date. The prohibition against lifetime limits is effective as of the first day of the plan year beginning on or after September 23, 2010 for all group health plans, insured or self insured, whether grandfathered or not. The elimination of annual limits on essential benefits is phased in with a final effective date of January 1, 2014.

Essential Benefits. Beginning in 2014 the law will require a minimum set of benefit provisions for all plans offered through the Exchange. Since the Exchange's plans will be insured and designed for groups under 100 lives and for individual policies, the new rules are silent concerning self insured plans and insured plans sponsored by employers with more than 100 employees. The law gives broad discretion to the Secretary of Health and Human Services (HHS Secretary) as to what benefits may continue to contain annual limits, albeit restricted. In defining restricted annual limits, the Health Reform Law requires the HHS Secretary to ensure that access to necessary services remains available with only a minimal impact on premiums (PHSA Section 2711(a)(2). The Interim Final Rules on annual limits reflect that standard.

Permissible Annual Limits. The Health Reform Law allows/provides for specific annual limits for Cafeteria Plan Health Care Spending Accounts: $2,500 per employee effective for tax years beginning in 2013. The Interim Final Rule will permit the use of annual limits for Health Reimbursement Accounts (with rollover) (under IRS Notice 2002-45) which are "integrated with" other group health coverage. Annual limits also will apply to Medical Savings Accounts and Health Savings Accounts in accordance with federal law without violating Health Reform Rules, since they are not health plans.

Annual Limits on Essential Benefits. The new Rule will allow annual limits on essential benefits under group health plans, whether insured on self-funded, between now and January 1, 2014, but they may not be less than the following table:

Plan or Policy Years:	Annual Limit
Beginning on or after 9/23/2010 but before 9/23/2011	$ 750,000
Beginning on or after 9/23/2011 but before 9/23/2012	$ 1,250,000
Beginning on or after 9/23/2012 but before 1/1/2014	$ 2,000,000

Annual Limits Apply on an Individual by Individual Basis. Although the new Rule permits annual limits on essential benefits prior to 2014, it prohibits a family annual limit. The new Rule makes it clear that if a family limit is met, and another family member incurs eligible expenses, then those expenses must be reimbursed under the terms of the plan without regard to the fact that the family has already maximized the annual family benefit.

Health Reimbursement Accounts (with Rollover of Unused Balances). The new Rule explicitly allows these specific types of reimbursement plans to have annual limits so long as they are "integrated with" other group health coverage (e.g. HRA reimburses enrollee for outpatient surgery deductibles) when the other group health coverage itself complies with the Health Reform Laws. Health Reform Law allows for pre-2014 annual limits but only for essential health benefits as defined by the Law and determined as such by the Secretary of health and Human Services. The new Rule also makes it clear that retiree-only HRAs are not subject to Section 2711.

Mini-Med Type Plans. The Health Reform Law requires that any restrictions on annual limits must continue to ensure access to necessary services with a minimal impact on premiums. The new Rule delegates this responsibility to the Secretary of Health and Human Services who must develop a program which will allow a waiver if implementation of this annual limit provision would result in a significant decrease in access to benefits or a significant increase in premiums. As we all know, plan sponsors occasionally offer very limited health care coverage to part time employees or to full time employees with short service, through so-called "mini-med" programs. On their face, these programs currently provide access to necessary services with annual limits that are far less than those specified in this Interim Final Rule. We expect that the HHS position on this issue will allow mini-med plans to continue to exist at least for the near term. We will keep you informed of developments.

Rescissions

Effective date. The Rescission Rule applies to all plans insured or self insured, whether grandfathered or not, as of the first day of the plan year beginning on or after September 23, 2010.

Under the PPACA, rescission is permitted only in the event of fraud or misrepresentation. If the insurer intends to cancel existing coverage based on fraud or misrepresentation, the insurer must provide prior notice and only as permitted under the rules of the network plan (if there is a network involved). PPACA requires that the insurer meet certain standards in its agreements with PPO networks.

HIPAA Non-discrimination Rules. The Interim Final Rule also prohibits cancellation or denial of health care plan coverage based on an individual's health status.

Applicability to Group Health Plans. The new rule clarifies the law by explicitly stating that the prohibition applies not only to rescission of coverage for an individual, but also a rescission of coverage for groups of individuals (i.e. employer-sponsored plans). If the plan sponsor, for example, in applying for group health coverage, intentionally misrepresents a material fact (e.g. they are actually dynamite handlers not just a service organization), the insurer retains the right to rescind coverage for the entire group.

Definition of Rescission. For purposes of the Interim Final Rule, a rescission is a cancellation or discontinuance of coverage retroactively. This definition does not include prospective cancellations and does not include cancellation for non-payment of premiums, even though cancellation is typically retroactive to the last day for which premium has been paid (earned).

Advance Notice Required. In the event that rescission meets the standards set by the Interim Final Rule, the Rule also imposes a 30 day advance notice to individuals and, if applicable, plan sponsors, regardless of whether the coverage is insured or self insured (i.e. a notice is required from the plan sponsor).

Patient Protections

Effective date. Patient protections contained in this Section of the Health Reform Law take effect as of the first day of the first plan year beginning on or after September 23, 2010. They do not apply to grandfathered plans.

In brief, group health plans, whether insured or self-insured, must allow enrollees to select a primary care provider (PCP) from among those available including pediatricians for children and to obtain OB-GYN services without referral from a PCP. It also requires provider organizations to offer emergency services to non-network patients, without any pre-authorization, that are necessary, without limitations and in the same manner as for network patients and at network pricing.

Choice of a Health Care Professional. Under plans which require enrollees to choose a primary care provider, the enrollee must now be able to choose any participating network provider who is available to accept the enrollee. Additionally, the plan/issuer must notify enrollees of their obligation to designate a primary care provider, including pediatricians for children. The notice must include the general terms of the plan including pediatric care. Failure to provide the notice of the coverage including any limitations or exclusions will result in all related services to be considered covered.

Plans which provide coverage in-network for OB-GYN services must allow female participants to obtain those services without first obtaining a referral/network authorization. The plan or issuer must provide notice that the plan has no authorization requirement for OB-GYN services. The Interim Final Rule also makes it clear that health care professionals may be any individual authorized under state law to provide OB-GYN services, not just physicians. The Interim Final Rule provides model notice language regarding choice of health care professional. The model notice must accompany any issuance of a summary plan description or plan benefit summary. See the attached for the model language. Note, for most plans this will be handled by the carrier. Only certain self-funded policies where the plan sponsor creates their own summary plan description will have to use this model.

Emergency Services. Ambulance service organizations, historically, provide ambulance services to the nearest medical facility without regard to the patient's available health plan coverage. This can result in disparities in cost-sharing and permissible services. Under the Interim Final Rule, the provider must provide emergency services without the need for a pre-authorization whether in network or not. Additionally, providers:

- Must provide necessary services without regard to coverage available under the plan or pursuant to any other plan term except for coverage exclusions or coordination of benefits rules.
- Must provide these services on the same basis as it would be for network members.

- Must provide these services based on the same cost-sharing (co-pays, co-insurance, etc.) as for network members.

Balance Billing. Providers, however, may balance bill (excess over what the plan actually pays and the allowance payable for network services) but only if the plan has paid a reasonable amount for the services. The Rule provides a formula applicable to determining what constitutes a "reasonable amount". For purposes of capitation plans (HMOs), there is yet another formula in the Interim Final Rule. For a description of these formulas, please consult the Interim Final Rule.

Definition of a Medical Emergency. For purposes of PPACA, an emergency medical condition is measured by the potential medical consequences that might reasonably be expected if no treatment were given, as determined by qualified hospital personnel.

Model Notices:

Effective date. The notices must be provided not later than the first day of the first plan year beginning on or after September 23, 2010.

The DOL notices can be included with other enrollment materials, provided the statement is prominent. The DOL models including instructions are attached. Below is the model language for each notice.

Dependent coverage to 26 notice requirement:

"Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information]."

Lifetime limit notice requirement:

"The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information]."

What's Next:

We expect carriers will be able to comply with all of the provisions for October 1, 2010 renewals. It is not clear yet how they will track grandfathered plans. We hope for some communication on this point soon. As always, contact your SML Account team if you have any questions.

Model Language for Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

The interim final regulations extending dependent coverage to age 26 provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The regulations require a plan or issuer to give such a child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year beginning on or after September 23, 2010. The notice may be included with other enrollment materials that a plan distributes, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

> Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity

Plans and issuers are required to give written notice that the lifetime limit on the dollar value of all benefits no longer applies and that an individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan or issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

These notices may be provided to an employee on behalf of the employee's dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

The following model language can be used to satisfy the notice requirement:

> The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

> [Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

> For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

> You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].