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Employer Compliance Alert

Patient's Bill of Rights under PPACA

Regulators Unveil Consumer Protections

June 25, 2010

Federal regulators released interim final rules implementing a new Patient's Bill of Rights under the Patient Protection and Affordable Care Act. The guidance addresses preexisting condition exclusions, retroactive rescissions, lifetime limits and annual dollar limits.

"These rules effectively put in place a basic set of consumer protections known over the years as the 'Patient's Bill of Rights.' This is a concept introduced 15 years ago and supported by both Democrats and Republicans," said Secretary of Health and Human Services Kathleen Sebelius in an e-mail statement.

The Federal Register will publish the rules on June 28. The new regulations, issued by the Departments of Health and Human Services, Labor and Treasury, will take effect for most plans on or after Sept. 23. For calendar year plans, the rules will take effect Jan. 1, 2011.

The interim final rules, which are nearly 200 pages, focus on PPACA provisions that apply to all health plans, including grandfathered health plans. According to consultants at Hewitt Associates, the provisions in the interim final rules adopt the following:

Preexisting condition exclusions: Prohibits preexisting condition exclusions for both benefit limitations and coverage.

Retroactive rescissions: Prohibits retroactive rescissions of coverage except in cases of fraud or an intentional misrepresentation of material facts, with no exception. Insurers and plans are required to provide at least 30 days advance notice of a rescission with time to appeal.

Lifetime limits: Prohibits lifetime limits on the dollar value of "essential health benefits" for any individual participating in a group health plan or group health insurance coverage. Additional notice and enrollment opportunity rules apply for individuals whose coverage or benefits ended by reason of reaching a lifetime limit.

Annual dollar limits: Restricts annual dollar limits on "essential health benefits" to no less than \$750,000 beginning Sept. 23, 2010, \$1.25 million beginning Sept. 23, 2011, and \$2 million beginning Sept. 23, 2012 but before Jan. 1, 2014. Good faith compliance with a "reasonable interpretation" of what is an essential health benefit will be allowed until regulations defining that term are issued.

"The interim final rule allows group health plans or health insurance coverage that has an annual dollar limit on benefits below the restricted annual limits permitted, such as limited benefit plans, to seek a waiver to delay compliance with the rules on restricted annual limits if the plan can prove that its current annual limits are necessary to prevent a significant loss of coverage or increase in premiums," Hewitt experts note. "The restriction on annual limits does not apply to health flexible spending arrangements, medical savings accounts or health savings accounts."

The guidance also clarifies that "the annual limit restriction does not apply to health reimbursement arrangements that are integrated with a group health plan that meets the requirements under health care reform or to stand-alone retiree-only HRAs."

The rules also provide consumer-protection mandates that apply to non-grandfathered plans, including:

- Prohibiting group health plans or health insurance issuers from requiring a referral for OB-GYN care or from allowing a pediatrician to be a designated primary care provider;
- Prohibiting prior approval for emergency care or higher cost-sharing amounts for out-of-network emergency care; and
- Requiring a "reasonable" reimbursement for providers of out-of-network emergency care before balance billing is allowed.

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