December 15, 2010

4 Overview: Patient Protections under ACA

- The Departments of Health and Human Services (HHS), Labor, and Treasury published a regulation addressing several provisions of ACA.
- The new regulation includes requirements related to preexisting condition exclusions, annual and lifetime dollar limits, rescissions, choice of providers, and coverage of emergency services.
- Most of the requirements in the new regulation are applicable to both insured and self insurance health plans for plan or policy years beginning on or after 9.23.10 (six months after the enactment of the law).
- Next are summarized the main requirements under ACA in the areas previously mentioned.

Pre-Existing Conditions Exclusions

New Rule

- All group health plans and health insurance issuers offering coverage to individual or group health plans may not impose pre-existing condition exclusions or discriminate against those who have been sick in the past.

Applicability

- Applies to grandfathered and non-grandfathered plans and applies to self insurance and insured plans (individuals and groups coverage).

Important Dates

- With respect to children under 19 years of age, this provision is effective for plan years beginning on or after September 23, 2010.
- This requirement extends to all other individuals covered under the plan for plan years beginning on or after January 1, 2014.

MCS Action Plan

- Comply with the requirement for the applicable policies.
- Coverage eligibility for main insurance older than 19 years old on individual policies.

This document is intended to provide useful information to MCS clients, providers and/or beneficiaries. However, this communication does not constitute any type of legal counseling, nor does it substitute the judgment of any professional that you may consult.

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Annual and Lifetime Dollar Limits

New Rule

- All plans are prohibited from establishing lifetime and annual limits on the dollar value of benefits.
- Prohibits group health plans and health insurance issuers from imposing annual limits on the dollar value of benefits for any participant or beneficiary, effective for plan years beginning on or after January 1, 2014.
- During the transition period a group health plan or health insurance issuer may impose a restricted annual limit on the dollar value of essential health benefits.
- Annual limits on the dollar value of essential health benefits may not be less than the following amounts:
    - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011: $750,000;
    - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012: $1,250,000;
    - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014: $2,000,000; and
    - For plan or policy years beginning on or after January 1, 2014: the limits are eliminated.
- The regulation also provides that these restricted annual limits may be waived by the Secretary of HHS, if compliance with the interim final rules would result in a significant decrease in access to benefits or a significant increase in premium.
- **Essential Health Benefits** include at least the following general categories and the services covered within the categories:
    - Ambulatory patient services
    - Emergency services
    - Hospitalizations
    - Maternity and newborn care
    - Mental health and substance abuse services, including behavioral health treatment
    - Prescription drugs
    - Rehabilitative services and devices
    - Laboratory services
    - Preventive and wellness services and chronic disease management

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- Pediatric services, including oral and vision care

Applicability

- Applies to self insurance and insured plans. The lifetime limit rules apply to all grandfathered and non-grandfathered plans. The annual limits rules apply to grandfathered and non-grandfathered group plans, but do not apply to grandfathered health plans that are individual health insurance coverage. Grandfathered individual policies can still impose annual limits.

Important Dates

- Prohibition of Lifetime Limits: Starting September 23, 2010
- Restrictions on Annual Limits: Starting September 23, 2010 – Prohibited in 2014.

MCS Action Plan

- Eliminate the active lifetime limits in the benefits. Restricted annual limits will be applied to some benefits to minimize any impact.
- Eliminate annual limits in benefits, according to the law requirements.
- Apply waiver approved on September 24, 2010, by the Office of Consumer Information and Insurance Oversight of the Department of Health and Human Services of the United States, for pharmacy coverage that have annual limits (which include brand drugs). For the generic drugs only coverage, the limit is eliminated.

Restrictions on Rescissions of Coverage

New Rule

- Under the regulation, insurers and plans are prohibited from rescinding coverage – for individuals or groups of people – except in cases involving fraud or an intentional misrepresentation of material facts, as prohibited by the terms of the plan or coverage.
- Insurers and plans seeking to rescind coverage must provide at least 30 days advance notice to give people time to appeal. There are no exceptions to this policy.

Applicability

- The Regulation applies to grandfathered and non-grandfathered plans and applies to self-funded and insured plans (individual and group coverage).

MCS Plan

- Comply with the requirement for the applicable policies.

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Choice of Providers

New Rule

- Group health plans and health insurance issuers offering coverage to individual or group health plans must allow an individual to choose his or her primary care physician, must allow a child to designate a pediatrician as his or her primary care physician, and must allow a woman to see a health care professional specializing in obstetrics or gynecology without an authorization or referral requirement.

    - Pediatrician – If plan requires child to designate a primary care provider, the plan must permit the child to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's PCP if the provider participates in the plan's network and is available to accept the child.
    - OB-GYN – A plan may not require a woman to obtain an authorization or referral to obtain coverage by a participating health care professional specializing in obstetrics or gynecology. The requirement does not apply to a nonparticipating (out-of-network) professional.

Applicability

- The Regulation only applies to non-grandfathered plans and only applies where the plan uses a network of providers. The Regulation applies to both self-funded and insured non-grandfathered plans (group and individual coverage).

MCS Plan

- No impact on MCS policies.

Coverage of Emergency Services

New Rule

- The statute generally requires that group health plans and health insurance issuers offering coverage to individual or group health plans must cover emergency services (as defined in ACA) without prior authorization and regardless of whether the service was provided in-network or out-of-network.

Applicability

- The Regulation applies to both insured and self insurance plans, but only applies not non-grandfathered plans.

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MCS Plan

- No impact on MCS policies.

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MCS health policy program