Healthcare Reform: Regulations Issued on Early Compliance Requirements

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The last Compensation and Benefits Briefs column dealt with the Patient Protection and Affordable Care Act (H.R. 3590) signed into law March 23, 2010, along with the modifications made by the Health Care and Education Tax Credit Reconciliation Act of 2010 signed into law March 30, 2010. Most commentators refer to the two pieces of legislation together as "PPACA," which is how they will be referred to in this column. The focus of the column will be on regulations that have been issued since March 2010. These regulations elaborate on the compliance requirements under PPACA starting in 2010 and extending into 2011.

The regulations will be discussed in the order in which they were issued. All regulations were issued jointly by the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services, which shall be referred to hereafter as the "Joint Agencies."

DEPENDENT COVERAGE

A new definition of "dependent" added by PPACA was the subject of interim final regulations issued by the Joint Agencies in the *Federal Register* on May 13, 2010.[1] Under the new definition of "dependent," a child must be offered the ability to elect coverage under a parent's health plan until age 26. The child does not have to be financially dependent on the parent, does not have to be in college, can be married (although the spouse of the child or a child of the child [i.e., the grandchild of the parent in question] is not eligible for enrollment), and can be employed by an employer that offers health coverage. Grandfathered plans do not have to offer this coverage if the dependent is eligible on his or her own for employer health plan coverage.

Even though it would appear likely that expenses for older children in the aggregate would exceed those for younger children, the regulations are explicit that there can be no difference in the premium charged for a dependent based on the dependent's age.

While a newly eligible dependent will be granted a special enrollment opportunity, he or she may face a preexisting condition restriction if the dependent has incurred a 63-day period during which he or she has not had health plan coverage.

GRANDFATHERED PLANS

A grandfathered plan is exempt from the following PPACA requirements: preventive care, expedited claims review, choice of providers, cost-sharing/deductibles, and guaranteed issue. A grandfathered plan is not exempt from the requirements concerning annual/lifetime benefit limits, dependent coverage to age 26, rescission (i.e., a retroactive cancellation of coverage), and preexisting condition exclusions.

On June 17, 2010, the Joint Agencies issued interim final rules for determining whether or not a health plan is grandfathered. The regulations make it clear no policy sold to an employer or individual after March 23, 2010, will be grandfathered. This means merely a change by an employer from one insurance company to another would automatically result in a loss of grandfathered coverage. However, the Joint Agencies are reconsidering the change in carrier provision.

In addition, even for those policies in effect on that date the following changes in the plan will cause it to lose grandfathered status:

- Elimination of coverage for a particular condition;
- Any increase in the co-insurance percentage (e.g., having participants pay 25% of the total cost versus the previous 20%);
- Any increase in the deductible/out-of-pocket amount if it exceeds medical inflation plus 15%;
- Any increase in a co-payment if it exceeds the greater of $5.00 (adjusted for medical inflation) or medical inflation plus 15%;

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- A decrease in the employer contribution by more than 5% of the contribution rate in effect on March 23, 2010 (Note: This is true for each type of coverage, not just employee coverage only; hence a decision to stop subsidizing dependent coverage would result in a loss of grandfathered status.); and
- An imposition of or reduction in the annual limit that did not exist on March 23, 2010.

Given how strict these rules are, it is generally believed that almost all small-employer group health plans will lose grandfathered status within a year or two especially since such plans are the most likely to seek cost relief by changing insurance carriers.

PREEXISTING CONDITION/LIMITS/ RESCISSIONS/PATIENT PROTECTION

The Joint Agencies in the June 28, 2010, *Federal Register* issued regulations that address four separate PPACA provisions.[2] These new interim final rules take effect for plan years beginning on and after September 23, 2010. They all apply to all plans including grandfathered plans except for the patient protection provisions, which do not apply to grandfathered plans.

The first provision prevents a plan from excluding a child under age 19 from coverage due to a preexisting condition. This applies to all group health plans and insurers, even if grandfathered. Starting in 2014, no preexisting condition exclusion can be applied to any participant.

The second provision prevents coverage being rescinded due to a mistake in the application unless the omission of relevant information actually constitutes fraud. An insurer can still refuse to continue coverage prospectively. In addition, coverage can still be cancelled retroactively if it is due to the failure of the participant to pay the appropriate premiums.

The third provision is no annual or lifetime limit on the amount of benefits provided under a plan. Until 2014, these restrictions apply only to "essential health benefits." While the term "essential health benefits" is not defined in the regulation, it does state the term will include hospitalization, emergency treatment, maternity benefits, prescription drugs, laboratory services, and mental health services, so there is not too much left that is not essential. Starting in 2014, there can be no annual or lifetime limit on any type of benefit. The regulations expressed a concern about the effect the limit restrictions would have on what is called a "mini med" plan, which for many part-time workers is the only coverage made available. It appears the Secretary of Health and Human Services could decide to waive the limit rules for mini-med plans if the result otherwise would be no coverage available or such coverage being unaffordable. The Secretary has indeed granted a one-year waiver to several mini-med plans.

The fourth provision concerns patient protections. These rules do not apply to grandfathered plans and include:

- The right for a patient to be able to select a primary care physician, pediatrician, obstetrician, or gynecologist without a referral although the plan can require that this selection be made from physicians in the plan's preferred provider network; and
- The right to seek emergency care from an out-of-network provider under the same conditions as an in-network provider (although the out-of-network provider can balance bill the patient for the difference in its charges to what would be charged by an in-network provider).

PREVENTIVE SERVICES

On July 19, 2010, in the *Federal Register* the Joint Agencies issued interim final regulations on what preventive services must be included in a health plan.[3] These regulations are effective for nongrandfathered group and individual health plans for plan years beginning on or after September 23, 2010. These preventive services must be provided with no cost-sharing involved (i.e., no copay or deductible that must be met first).

The initial set of preventative services are: (1) mammograms; (2) colonoscopies; (3) cancer screenings; (4) blood pressure and cholesterol tests; (5) weight loss/ smoking-cessation counseling; (6) health checkups; and (7) immunizations for children. Additional services will be added in future years but plans will have one year after the formal announcement of the additional services to provide them. The three publications that will have authority to make the recommendations are:

- Evidence-based items or services rated A or B by the United States Preventive Services Task Force recommendations;
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Preventive care and screening for women, infants, children, and adolescents in guidelines issued by the Health Resources and Services Administration.

An insurance plan that uses a preferred provider model does not have to provide these services at no cost if the plan participant uses a provider outside the PPO network. This regulation will impact office billing because cost-sharing can be billed if the primary purpose of the visit was other than providing the preventive service but there is no definition in the regulations of how to determine the primary purpose of the visit.

EXPEDITED CLAIMS PROCEDURES

These interim final regulations were issued by the Joint Agencies on July 23, 2010, in the *Federal Register*.[4]

They apply to all nongrandfathered health plans starting with plan years beginning on or after September 23, 2010. This means for most plans that follow a calendar-year plan, these new claims procedures must be in place on January 1, 2011.

The most important aspect of these regulations is the fact they require a final decision on an urgent care claim be made within 24 hours unless the participant fails to provide enough information. Under previous claims rules under the Employee Retirement Income Security Act of 1974 (ERISA), a plan had 72 hours to make such a decision. If the plan does not adhere to the new deadline, the plan participant can immediately proceed to an external review of the claim or to court.

In addition to speeding up the timing of claim review, the regulations impose a strict standard to ferret out any possible conflicts of interest. For commercially insured plans, the insurer cannot provide compensation such as a bonus to its employees who are involved in claims review that is in any way based on claim denials. Likewise, outside experts cannot be hired if the experts are known for the outcome of their decisions rather than their credentials.

An appeal to an independent outside party called an "Independent Review Organization" will be available. This outside review is already in effect in most states; but for those states without such an outside review, the federal government will provide such a review as of September 23, 2010.

CONCLUSION

The regulations issued so far are those required under PPACA to be issued quickly after enactment. For the most part, they address features of PPACA that appear to have immediate appeal to patients such as the coverage of older dependents, the dropping of co-pay requirements for certain preventive services, and the ability to immediately appeal a denial of a claim. What remains to be seen is the financial impact these changes (as well as the more substantive ones taking effect in future years) will have on premiums. There is still a great deal of concern that liberalizations in plan terms will create unaffordable premium increases that may result in employers abandoning the private insurance market altogether and letting employees purchase insurance through the exchanges that take effect in 2014. Initial signs of the cost impact of these changes will occur during the 2011 plan year as premiums rise to take into account the increased exposure of insurers. If premiums spike dramatically, further modification of the PPACA legislation will undoubtedly occur. ■

The above discussion is intended to briefly summarize certain recent legal developments in employee benefits, but is not intended to be legal advice and must not be relied upon as such. All readers are urged to raise any concerns they may have based on matters discussed in this column with experienced benefits legal counsel.

REFERENCES

1. Interim final rules for group health plans and health insurance issuers relating to dependent coverage of children to age 26 under the Patient Protection and Affordable Care Act. *Federal Register.* May 13, 2010:27122-27140.
2. Patient protection and affordable care act: preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protections. *Federal Register.* June 28, 2010:37188-37241.
3. Interim final rules for group health plans and health insurance issuers relating to coverage of preventive services under the Patient Protection and Affordable Care Act. *Federal Register.* July 19, 2010:41726-41760.
4. Interim final rules for group health plans and health insurance issuers relating to internal claims and appeals and external review processes under the Patient Protection and Affordable Care Act. *Federal Register.* July 23, 2010:43330-43364.