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## **PPACA Regulations:**

- Annual & Lifetime Limits**
- Choice of Providers**
- Emergency Care**

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American Benefits Council Call

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# Annual & Lifetime Limits

- General Rule – Plan may not impose annual or lifetime dollar limits on essential health benefits.
- Applies to total dollar limit (for example – overall annual limit of \$500,000 for all benefits under plan).
- Regulations are silent on whether “number of visits” or “per procedure dollar limits” are allowed, so appears that these limits continue to be permitted.

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# Essential Health Benefits

Preamble says that, until agencies further define “essential health benefits,” plans should use “good faith efforts” to comply with a “reasonable interpretation” of term.

## Essential Health Benefits:

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity & Newborn Care
- Mental Health & Substance Use Disorder Services (including behavioral health treatment)
- Prescription Drugs
- Rehabilitative & Habilitative Services & Devices
- Laboratory Services
- Preventive & Wellness Services & Chronic Disease Management
- Pediatric Services, including Oral & Vision Care

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# Restricted Annual Limits

- Plan may impose “restricted annual limits” until 2014.
  - 2011 Plan Year – Must be at least \$750,000.
  - 2012 Plan Year – Must be at least \$1.25 million.
  - 2013 Plan Year – Must be at least \$2 million.
- 2014 – No more annual limits on essential health benefits.

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## Special Re-Enrollment Right If Already Reached Lifetime Max

- If individual previously reached lifetime maximum, plan must allow re-enrollment (similar to age 26 rules).
- Plan must provide written notice.
  - May be provided to employee/subscriber or provided in enrollment materials if “prominent.”
  - DOL has issued model notice.
- Must allow 30 days to re-enroll
  - Must take place by start of plan year.
  - Similar to HIPAA special enrollment.

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# Scope of Annual / Lifetime Limits Rule

- Not applicable to:
  - Health FSA, MSA, HSA
  - Integrated HRA (coupled with plan that does comply with rule)
  - Retiree-Only HRA (due to retiree-only exception)
  - HIPAA Excepted Benefits (limited scope dental/vision, disease-only, fixed indemnity, supplemental)
- Agencies requested comments as to whether should be applicable to non-retiree stand-alone HRA.

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## Waiver from Annual/Lifetime Limit Rules

- Plans may request waiver from Secretary of HHS. Secretary to issue guidance on how to apply.
- Secretary may waive requirement until 2014 if compliance would result in “significant decrease in access to benefits” or “significantly increase premiums.”
- Preamble says geared toward limited benefit (mini-med) plans.

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# Choice of Providers

- Participant may choose any primary care physician available to accept participant.
- Child may choose pediatrician as long as in-network and available to accept child.
- Woman may see health care professional in obstetrics/gynecology without authorization or referral.
  - Not required to be a physician.
  - Plan may require further treatment to be subject to authorization or referral.

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## Choice of Providers - Notice

- Plan must provide notice of rights related to choice of physician.
- Regulations provide model language.
- Must be provided in SPD or similar description of benefits.

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# Emergency Coverage

- Must cover without prior authorization – whether in-network or out-of-network (may require notification).
- Must cover without regard to whether in-network.
- Must not impose requirement/limitation more restrictive for out-of-network than in-network.
- May not impose terms other than COB, exclusions, waiting periods, or applicable cost sharing.
- Cost sharing restrictions (different rules depending on type of cost sharing).

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## Emergency Care Cost Sharing Limits

### *Deductibles & Out-of-Pocket Maximums*

- May impose deductible or out-of-pocket maximum for out-of-network if applies generally (not just to emergency).
- Example: Plan has \$250 general deductible for in-network care & \$500 general deductible for out-of-network care. If participant seeks out-of-network emergency care, subject to \$500 general deductible for out-of-network care (but could not have separate out-of-network emergency care deductible).

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# Emergency Care Cost Sharing Limits

## *Copayments & Coinsurance*

- Only may charge in-network cost sharing.
- Must use base amount that is greater of:
  1. Median of Negotiated In-Network Rate
  2. Out-of Network Rate (e.g., UCR)
  3. Medicare Rate
- Out-of-Network provider may “balance bill” for charges over this base amount.

# Emergency Care Cost Sharing Limits

## *Copayments & Coinsurance*

### Example:

- Plan charges 50% for out-of-network services / 80% in-network services.
  1. Negotiated rates for network emergency services are \$75, \$100, \$110 (median is \$100).
  2. UCR rate (for out-of-network) is \$110.
  3. Medicare rate is \$80.

- Greater of 3 amounts on left is: \$110 (UCR rate).
- Plan may charge 80% of \$110 – or \$88.
- If provider charges \$125, provider may “balance bill” for \$37 (\$125 minus \$88).

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# Questions?



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