PPACA Regulations:
- Annual & Lifetime Limits
- Choice of Providers
- Emergency Care

Christy Tinnes

Groom Law Group

American Benefits Council Call

6/29/10

GROOM LAW GROUP

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.

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

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.

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.

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.

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.

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.

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.

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).

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).

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).

Questions?

Christy Tinnes

Groom Law Group

202-861-6603

ctinnes@groom.com