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Healthcare re-FORUM

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Patient Protections

On June 28, 2010, the Departments of Health and Human Services (HHS), Labor and Treasury (the Departments) issued interim final regulations (IFR) entitled "Patient Protection and Affordable Care Act: Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections." This IFR defines several mandates that will take effect for non-grandfathered plans on or after September 23, 2010 (for calendar year plans, the rules will take effect January 1, 2011). This issue of *Healthcare Re-Forum* reviews the reform rules involving the Patient Protections mandate. All non-grandfathered group health plans, both fully insured and self-insured, as well as non-grandfathered individual health plans, must comply with the guidelines listed below. Grandfathered group and individual plans are exempt from the Patient Protections mandate.

The Patient Protections mandate will have a significant impact on provider selection for plan members. The IFR clarifies requirements about how plan members can choose primary care providers, including the ability to choose pediatricians as primary care providers for children and required access to obstetric and gynecological care for women. In- and out-of-network emergency services are also reviewed.

Primary Care Provider Selection

If a plan requires members to choose a primary care provider (PCP), the plan will need to notify each member (or in the individual market, the primary subscriber) about his or her right to choose:

- Any participating PCP who is accepting new patients
- Any participating physician specializing in pediatrics as the PCP for a child (the pediatrician must be accepting new patients)

The ability to choose a pediatrician as a child's PCP does not change the general terms of insurance coverage for pediatric care. If there is a certain benefit not covered by the plan, the plan will not be required to cover that service even if the pediatrician recommends it as part of a treatment plan.

In addition, plans that provide coverage for obstetrical or gynecological care and require members to choose a PCP must notify members that there is no requirement to obtain prior approval or a referral for such care by in-network healthcare professionals in those specialties. As defined by the IFR, a healthcare professional who specializes in obstetrics or gynecology is any individual who is authorized under applicable state law to provide obstetrical or gynecological care.

While a female member will not need prior approval to see an OB/GYN, the OB/GYN must still follow the plan's policies on referrals to other providers and, if required, prior approvals for specific services.

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Emergency Services Provision

Plans that currently provide benefits for emergency services in hospital emergency departments need to be aware of the following requirements:

- Plans must provide coverage for emergency services without prior approval, whether those services are received from in- or out-of-network providers.
- The cost-sharing amounts (e.g., deductibles and coinsurance) for both in- and out-of-network emergency services must be the same, with members not being charged more for out-of-network emergency services.
- Out-of-network emergency services providers may sometimes bill patients for the difference between their charges and the amount collected from the plan (i.e., the allowed amount) and from the patient (i.e., copayment or coinsurance).
- The IFR establishes a formula to ensure plans pay an "appropriate amount" to non-network providers of emergency services (the formula's calculation should be reviewed in the IFR, along with the examples provided for further clarification).
- Cost-sharing requirements that plan members pay, such as deductibles or out-of-pocket maximums, may only apply for out-of-network emergency services in the same way they apply for all other out-of-network services.

Summary

The new IFR makes it clear that health plan members who are required to designate a PCP are able to select any available participating PCP, and that parents may choose any available participating pediatrician to be their children's PCP. The IFR also prohibits the requirement of a referral for obstetrical or gynecological care. The IFR sets specific requirements on how health plans should reimburse out-of-network providers for emergency services. Plans and insurers will need to charge the same cost-sharing amounts for emergency services that are obtained either in or out of a plan's network. These changes apply only to non-grandfathered individual market and group health plans, both fully insured and self-insured.

The "Patient Protection and Affordable Care Act: Pre-existing Condition Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections" IFR can be accessed through the following link:

http://www.dol.gov/federalregister/HtmlDisplay.aspx?DocId=23983&AgencyId=8&DocumentType=2

Future Topics:

- Modifications to Consumer Driven Products
- Self-Insured Plans as Impacted by Healthcare Reform
- New Cafeteria Plan Requirements