Additional Patient Protections

**Summary:** Adds key patient protections related to choice of primary health care professional, coverage of emergency services, and access to both pediatric and obstetrical and gynecological care.

**Status update:** On September 20, 2010, the Department of Labor (DoL) issued a frequently asked questions (FAQ) related to emergency services. Specifically, the FAQ clarifies issues related to balanced billing for emergency services by stating the following: “If a State law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums set forth in the regulations. Similarly, if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy the payment minimums. In both situations, however, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts, to prevent inadvertent payment by the patient. Nonetheless, even if State law prohibits balance billing, or if the plan or issuer is contractually responsible for amounts balance billed, the plan or issuer may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.”

**Next steps:**
- June 22, 2010 -- The Departments of Health and Human Services, Labor, and Treasury released an interim final rule (IFR) regarding patient protections among other items.
- Before August 27, 2010 – Comments due on IFR
- August 27, 2010 – Effective date of new regulations
- September 20, 2010 – The Department of Labor (DoL) issued a frequently asked question related to emergency services. Specifically, the FAQ clarifies issues related to balanced billing for emergency services

**Additional information:**

**Summary Interim Final Rule (IFR):**

*Notice requirement.* When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or
gynecological care without prior authorization. Accordingly, the IFR requires such plans and issuers to provide a notice to participants (in the individual market, primary subscribers) of these rights when applicable. Model language is provided in the IFR. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage, or in the individual market, provides a primary subscriber with a policy, certificate, or contract of health insurance.

**Balance billing and emergency services.** Out-of-network providers may balance bill patients for the difference between the providers’ charges and the amount collected from the plan. Plans are not required to cover balance billing amounts. The IFR does require that plans pay out-of-network providers a reasonable rate, which is defined to be the greater of the following:

- The amount negotiated with in-network providers for the emergency service furnished (if the plan has more than one negotiated amount with providers for a particular service, the basis for payment would be the median amount);
- The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing; or
- The amount that would be paid under Medicare for the emergency services.

**Exclusions.** A plan or issuer that has not negotiated with any provider for the delivery of health care but merely reimburses individuals covered under the plan for their receipt of health care is not subject to the requirements relating to the choice of a health care professional, whether it relates to primary care, pediatricians, or obstetrical/gynecological care but are subject to requirements relating to benefits for emergency services.

**Grandfathered plans.** None of these requirements apply to grandfathered health plans.

**Long summary:**

PHS Act sec. 2719A. Patient Protections (as modified by sec. 10101).

**Choice of health care professional.** Provides that if a group health plan or issuer offering group or individual coverage requires or provides for designation of a participating primary care provider, then the plan or issuer must permit the participant or enrollee to designate any participating primary care provider who is available to accept the individual.

**Coverage of emergency services.** Requires that if the plan or issuer provides or covers hospital emergency department services, it must cover them: (1) without the need for any prior authorization; (2) whether or not the provider is a participating provider; (3) in the same manner as if there were no such requirements or any limitation on coverage that is more restrictive than if the providers had a contractual relationship; and (4) at the same cost-sharing requirements (with certain exceptions) as for in-network services. Adopts a prudent layperson standard for the definition of "emergency medical condition." Defines "emergency service", with respect to an emergency medical condition, as (1) a medical screening examination (as required under §1867 of the Social Security Act (SSA)) within the capability of the emergency department of a hospital including ancillary services routinely available to the emergency department to evaluate such condition and, (2) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as required under §1867 to stabilize the patient.
Access to pediatric care. Requires a plan or issuer to permit the participant or enrollee to designate a physician who specializes in pediatrics as the child’s primary care provider if such provider participates in the plan or issuer’s network.

Access to obstetrical and gynecological care. Prohibits a plan or issuer from requiring authorization or referral in the case of a female participant, beneficiary or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Requires that professional to agree to otherwise adhere to the plan’s or issuer’s policies and procedures, including those regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. Applies to a group health plan or issuer that provides coverage for obstetric or gynecological care and requires the designation of a participating primary care provider by the enrollee, participant or beneficiary. This provision is not meant to waive any exclusions of coverage under the terms and conditions of the plan or coverage with respect to obstetrical or gynecological care or preclude the group health plan or issuer from requiring the obstetrical or gynecological provider to notify the primary care health care professional or the plan or issuer of treatment decisions.

Legislative text:
‘‘SEC. 2719A. PATIENT PROTECTIONS.
‘‘(a) CHOICE OF HEALTH CARE PROFESSIONAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

‘‘(b) COVERAGE OF EMERGENCY SERVICES.—
‘‘(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

‘‘(A) without the need for any prior authorization determination;

‘‘(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

‘‘(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

‘‘(i) by a nonparticipating health care provider with or without prior authorization; or

‘‘(ii) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

‘‘(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

‘‘(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of this Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

‘‘(2) DEFINITIONS.—In this subsection:

‘‘(A) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

‘‘(B) EMERGENCY SERVICES.—The term ‘emergency services’ means, with respect to an emergency medical condition—
“(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
“(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.
“(C) STABILIZE.—The term ‘to stabilize’, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
“(e) ACCESS TO PEDIATRIC CARE.—
“(1) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if such provider participates in the network of the plan or issuer.
“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.
“(d) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—
“(1) GENERAL RIGHTS.—
“(A) DIRECT ACCESS.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.
“(B) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.
“(2) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or coverage that—
“(A) provides coverage for obstetric or gynecologic care; and
“(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.
“(3) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to—
“(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or
“(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.”.