

Legislative Brief

Health Care Reform:

Provisions Effective for Plan Years Beginning on or After Sept. 23, 2010

September 23, 2010 marked the date that some of the first health care reform provisions under the Patient Protection and Affordable Care Act (PPACA) began to take effect. Provisions will continue to be implemented over the next few years. This Legislative Brief outlines the provisions impacting employer-based health plans that take effect for plan years beginning on or after **September 23, 2010**. Read below for specific information regarding each of the described provisions.

Dependent Coverage to Age 26

The health care reform law requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for this coverage. This applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans (grandfathered plans) unless the adult child has another offer of employer-based coverage through his or her own job. Beginning in 2014, children up to age 26 can stay on their parents' employer plan even if they have another offer of coverage through their own employer.

Limits on Lifetime and Annual Limits

In general, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary or impose unreasonable annual limits on the dollar value of benefits for any participant or beneficiary. This requirement applies to all plans. Annual limits will also be prohibited beginning in 2014.

No Pre-Existing Condition Exclusions for Children

Plans may not apply pre-existing condition exclusions to children under the age of 19. This rule applies to grandfathered group health plans and all new plans. Note that for plan years beginning on or after January 1, 2014, all pre-existing condition exclusions will be prohibited.

Prohibiting Rescissions

The health care reform law is designed to prohibit abusive rescissions of coverage by insurance companies when an individual becomes ill as a way of avoiding covering the cost of the individual's health care needs. Group health plans and health insurance issuers offering group or individual insurance coverage may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be cancelled without prior notice to the enrollee. This provision applies to all new and existing plans.

Coverage of Preventive Health Services

Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for preventive services. These plans also may not impose cost-sharing requirements for preventive services. This provision does not apply to grandfathered plans.

The recommended preventive services covered by these requirements are:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force;



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- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA.

Nondiscrimination Rules for Fully-Insured Plans

Fully-insured group health plans must satisfy nondiscrimination rules regarding eligibility to participate in the plan and eligibility for benefits. These rules prohibit discrimination in favor of highly compensated individuals. This provision does not apply to grandfathered plans.

Effective Claims and Appeals Processes

Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims. At a minimum, plans and issuers must:

- Have an internal claims process in effect;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist them with the appeals processes; and
- Allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

The internal claims process must initially incorporate the current claims procedure regulations issued by the Department of Labor in 2001. Plans and issuers must also implement an external review process that meets applicable state requirements and guidance that is to be issued. This provision does not apply to grandfathered plans.

Patient Protections and Selection of Providers

PPACA imposes three new requirements on group health plans and group or individual health insurance coverage that are referred to as "patient protections." These patient protections relate to the choice of a health care professional and benefits for emergency and OB/GYN services. They do not apply to grandfathered plans. The rules regarding choice of health care professional apply only to plans that have a network of providers.

Specifically, plans must allow enrollees access to any primary care provider that participates in its plan or network and is available to take on patients. This includes a pediatrician for children. Plans must also cover emergency services without higher cost-sharing for hospitals that do not participate in the plan's network and without prior authorization requirements. Services from an OB/GYN specialist must be available for women without referral or preauthorization.

Minimum Loss Ratio Requirement

Insurers must maintain certain minimum medical loss ratios and annually report on the percentage of health premiums used for claims reimbursement if offering group or individual health plans. Rebates must be provided to health plan participants if minimums are not met.

This Fickewirth and Associates Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.