



## CLOSE-UP: What happens September 23, 2010?

September 8, 2010

It all starts then...or does it? September 23, 2010 is simply the kick-off date for several provisions of the Patient Protection and Affordable Care Act (PPACA), but not the date when members are affected. These are some of the provisions everyone has been talking about, because many of the changes directly affect health coverage benefits.

The changes will affect new plans and existing plans on the first day of the first plan year on or after September 23, 2010. From a practical standpoint, that means plan years beginning October 1, 2010, so most people will not be affected by these changes until their coverage renews in the weeks and months ahead. Therefore, many employers may not need to make changes to comply with these provisions until 2011. Employers who already provide many of the benefits and protections provided for under the PPACA will experience relatively little change.

We have provided detailed information about most of these changes in prior Close-Ups, which can be found in the "Issues" section in the top left-hand corner of the web page.

### What September 23 changes apply to all group and self-funded plans, including grandfathered plans?

If you offer group coverage or are a self-funded plan issued on or before March 23, 2010, and have elected grandfathered status, you are *still required* to comply with the five provisions listed below.

**Dependent Coverage** – All health plans that cover children as dependents must continue to make that coverage available until the adult dependent reaches age 26, regardless of whether the adult dependent is married or a student. This provision does not apply to the child of a child receiving dependent coverage or to dependents who are offered employer coverage directly.

This change affected many dependents who graduated in June and faced a lapse in coverage. As a result, effective June 1, 2010, Highmark continued coverage for

most insured groups for young adults under age 26 whose coverage ended June 1, 2010, or later and who were covered on their parents' policy.

Plans will implement the federal requirement in plan years beginning October 1, 2010. For plan years beginning before 2014, the federal requirement to extend dependent coverage does not apply to grandfathered group health plans with respect to children who are eligible for other employer-sponsored coverage other than through a parent's employer.

**Lifetime Dollar Limits** – Health plans can no longer impose lifetime limits on the dollar value of essential health benefits. The Department of Health and Human Services (HHS) will determine the meaning of essential benefits\*, which will affect how eliminating lifetime dollar limits will apply. If state and/or Federal laws permit, plans can continue to impose lifetime limits on specific "nonessential" covered benefits.

**Annual Dollar Limits** – Health plans must begin to phase out annual limits on the dollar value of essential health benefits. Annual limits will be phased out over the next three years, and will be banned for most plans by 2014. The following chart illustrates the phase-out plan:

Plan Years Beginning On or After	Annual Limits
September 23, 2010	Plans can set limits no lower than \$750,000
September 23, 2011	Minimum limit increases to \$1.25 million
September 23, 2012	Minimum limit increases to \$2 million
January 1, 2014	All annual dollar limits on coverage for essential health benefits will be prohibited

**Pre-existing Condition Exclusions on Children** – Health plans can no longer exclude coverage for children under age 19 because of pre-existing conditions. However, plans can require parents to enroll

their children only during a fixed annual enrollment period to ensure they don't wait until a child gets sick to buy coverage. For plan years beginning on January 1, 2014, this provision will be extended to include anyone who enrolls in health coverage.

**Rescissions** – Health plans, including individual grandfathered plans, cannot rescind coverage once a member is covered, unless the member engaged in fraud or intentionally misrepresented a material fact under the terms of the health plan or policy. In these two cases, rescissions are permitted only with a 30-day prior written notice to the member and provided the rescission does not violate other applicable law.

**Medical Loss Ratios (MLRs) Reporting** – Individual and group health insurance coverage must report annually to HHS the proportion of premium dollars spent on clinical services and quality improvement activities for publication on the HHS website. This provision does not apply to self-insured plans.

#### What September 23 provisions do *not* apply to grandfathered plans?

**Preventive Services** – Individual, group and self-funded plans must cover certain preventive care services, as recommended by governmental agencies, without any member cost-sharing requirements, such as deductibles, copayments or coinsurance. These services include:

- High-priority recommendations rated A or B by the U.S. Preventive Services Task Force (USPSTF)
- Immunizations for routine use recommended by the Centers for Disease Control and Prevention (CDC)
- Preventive care and screening for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA)
- Guidelines for women supported by HRSA

**Discrimination Based on Salary** – Fully-insured group health plans are prohibited from discriminating with respect to eligibility to participate and benefits in favor of certain highly compensated employees. Under prior law, only self-insured plans were subject to this nondiscrimination requirement.

**Quality of Care Reporting Requirement** – Individual and group health insurance coverage and self-funded plans must submit an annual report to HHS and to enrollees (during each open enrollment period),

explaining how the health plan's benefits and provider reimbursement policies improve quality of care, including wellness and health promotion activities. Reporting regulations clarifying this requirement are to be issued no later than March 23, 2012. Therefore, it appears that plans and issuers will not be required to submit the report until after the regulations are issued.

**Choice/Direct Access Requirements** – Plans that require members to select a Primary Care Physician (PCP) must allow their members to designate any participating primary care physician or pediatrician (for a child). Female members cannot be required to obtain a prior authorization to visit a participating obstetrician/gynecologist.

**Coverage for Emergency Services** – All plans that cover hospital emergency services must provide that coverage without requiring a prior authorization. Plans must also treat emergency services as in-network in terms of cost-sharing, regardless of whether the provider participates in the health plan's network.

**Internal Appeals/External Reviews** – Plans are required to have in place an internal appeals and an external review process for coverage determinations and claims decisions that meets the requirements of the Act. The plan and insurer must comply with a number of new requirements, including notifying enrollees of available processes and the availability of consumer assistance or ombudsman programs, and allowing enrollees to review claim files and present evidence and testimony. Plans must continue an individual's health care coverage pending the outcome of the appeal.

*\*Essential benefits must include the following categories and the items and services covered within these categories: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. At this time, HHS has not released the list of essential benefits. We will update you with that information as soon as it becomes available.*

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Please note that information contained in this Close-Up is based on our understanding of the Patient Protection and Affordable Care Act of 2010, as amended, and guidance as of the date of this publication.