



New Wave of Health Care Reform Provisions Begin To Take Effect for Medical Plans

September 27, 2010

What is going to impact your plan?

A new wave of provisions of the Patient Protection and Affordable Care Act (PPACA) went into effect last week for plan years renewing on or after, September 23, 2010. Some of the provisions will not affect groups as they renew, if the group maintains a grandfathered status, while other provisions will impact all employer sponsored health plans. Below is a list highlighting the major provisions that are now in effect. If you have any specific questions about these provisions as they pertain to your medical plan, please contact your Unison Benefit Consultant.



Provisions In Effect September 23, 2010

Covering dependents up to age 26.

Group health plans with dependent child coverage must make available coverage for the enrollee's adult children who are younger than age 26, regardless of whether or not the dependent is a full-time student, disabled, or married.

Prohibition on lifetime and annual benefits.

Lifetime or annual benefit limits cannot be imposed by group health plans. A phase-in rule applies for annual benefit limits and "essential health benefits".

Prohibition on rescissions of health coverage.

Health insurance issuers in the group and individual market may not rescind an enrollee's coverage, except where an individual has engaged in fraud or made an intentional misrepresentation of material fact as prohibited under the terms of the plan or coverage.

Requirement to provide preventive care services.

All plans are required to cover, without any cost-sharing, preventive services and immunizations that are recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control (CDC). Also required to be covered, without any cost-sharing, are certain child preventive services recommended by the Health Resources and Services Administration. (Not applicable to grandfathered plans.)

Requirement that insurers maintain minimum loss ratios.

Insurers offering group or individual health insurance must annually report on the percentage of health premiums used for claims reimbursement and must maintain certain minimum medical loss ratios. If minimums are not maintained, rebates must be provided to health plan participants.

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Developing standards for summaries of benefits.

Effective for plan years beginning on or after Sept. 23, 2010, the Department of Health and Human Services (HHS) has been ordered to develop standards for use by group health plans and health insurers in compiling and providing a summary of benefits and explanation of coverage. The summaries must be in a uniform format, using easily understood language, and must include uniform definitions of standard insurance and medical terms. The explanation also must describe any cost-sharing, exceptions, reductions, and limitations on coverage, and use examples to illustrate common benefits scenarios.

Insured health plan compliance with nondiscrimination rules.

Insured group health plans must comply with existing nondiscrimination rules for self-funded plans. These include nondiscrimination rules for eligibility and benefits. Previously there were no federal laws for fully insured health plans that prevented discrimination in favor of the highly compensated. In other words, employers could establish fully insured medical reimbursement plans for a select group of employees, such as key employees. That is no longer true. (Not applicable to grandfathered plans.)

Group health plan reporting requirements.

The HHS will establish reporting requirements for group health plans and health insurers offering group or individual health insurance coverage. Reporting will include information on plan or coverage benefits and health care provider reimbursements. HHS has two years after enactment to publish regulations that provide criteria for health provider reimbursement structure. Then, within 180 days of the publication of regulations, the Government Accountability Office must submit a report to Congress reviewing the impact of the requirements on the quality and cost of care.

Implementing effective claims appeals processes.

Group health plans and a health insurer must implement an effective process for appeals of coverage determinations and claims, including an internal and external claims appeal process and employee notification. (Not applicable to grandfathered plans.)

Expanding patient selection of providers.

Effective for plan years beginning on or after Sept. 23, 2010, health insurance plans must allow enrollees to select any participating primary care provider available, including a pediatrician for children, and to cover emergency services provided at a hospital emergency department regardless of the hospital's participation in the plan preferred provider network and without prior authorization requirements. Female enrollees must be able to obtain obstetrical/gynecological specialist services without a referral from another primary care provider. (Not applicable to grandfathered plans.)