



INSURANCE SERVICES



Health Care Reform Update

July 28, 2010

www.siho.org

As you know, the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. Since that time SIHO has been sending periodic e-news regarding the provisions of the bill. In order to provide structure, the following timeline will be included with each newsletter; In addition, each newsletter will provide clear and pertinent information about a selected few topics from this timeline **and will be highlighted in red.**

Immediately

- Grandfather Status
- Small Business Health Insurance Tax Credit
- Reinsurance Program for Early Retiree Health Coverage (June 1, 2010)
- High-Risk Pool Coverage (July 1, 2010)
- Health Insurance Informational Portals (July 1, 2010)

Plan Years Starting on or after September 23, 2010

- Dependent Coverage through Age 26
- No Pre-Existing Condition Exclusions for Children
- No Lifetime Benefit Limits and "Restricted" Annual Limits
- No Rescissions (except Fraud)
- All Emergency Services Covered In-Network*
- **No Cost Sharing for Specific Preventive Services***

Note: *Indicates provision does not immediately apply to Grandfathered Group Health Plans.

2011-2013

- Increased tax on HSA and MSA Withdrawals not used for Medical Expenses
- Public Long-Term Care Program
- Minimum Loss Ratio (MLR) Requirements
- Comparative Effectiveness Studies Begin
- All Group Plans Must Report Benefits to HHS
- Additional Medicare Tax Levied onto High Income Individuals

2014 and Beyond

- Exchanges
- Annual Taxes on Private Health Insurers
- Monetary Penalties for any Individual Failing to Purchase Coverage
- Expanded Medicaid and Tax Credits for Low Income Individuals
- Employer Responsibility Requirements and Free Choice Vouchers
- Guarantee Issue and Guarantee Renewal
- Pre-Existing Exclusions, Annual Limits, and Lifetime Limits Eliminated
- Restricted Underwriting Factors
- Wellness Program Changes
- Excise Tax (2018)

No Cost Sharing for Specific Preventative Services*

The Departments of Health and Human Services (HHS), Labor, and the Treasury issued regulations, which require health plans to cover evidence-based preventive services and eliminate cost sharing requirements for such services. The regulations will take effect on plan years starting after September 23, 2010. The benefits to be covered are as follows:

- Preventive services receiving high marks from the U.S. Preventive Services Task Force
- Immunizations recommended by the U.S. Centers for Disease Control and Prevention immunization practices advisory council
- The preventive care and screenings recommended for babies, children and adolescents by the federal Health Resources Services Administration (HRSA).
- The preventive care and screening recommended for women that will be described in guidelines to be developed by Aug. 1, 2011.

These new rules provide access to services such as blood pressure, diabetes, and cholesterol tests; many cancer screenings; routine vaccinations; pre-natal care; and regular wellness visits for infants and children.

The U.S. Preventive Services Task Force can put a service on the preventive services list by giving it a grade of A or B. The task force now assigns grades of A to services such as cholesterol screenings for men over 35 and women over 45, screenings for high blood pressure in adults ages 18 and older, and screenings for colorectal cancer in adults ages 50 to 75.

Services that receive B grades from the task force include routine cholesterol screenings for young adults, screening for diabetes in adults without symptoms who have high or moderately high blood pressure, and mammography for women ages 40 and older every 1 or 2 years.

If a preventive service “is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit,” according to the text of the regulation. If an individual goes to a doctor for a preventive service, such as a blood pressure check, and also gets some other kind of treatment, such as care for an earache, the plan can apply the usual cost-sharing rules to the care for the earache.

*The new regulations will not apply to grandfathered plans.

Additional News

The Departments of Labor (DOL) has released the Interim Final regulations for Internal Claims and Appeals and External Review Processes that will apply, for the first time ever, to self-insured plans.

The regulations are effective for plan years beginning after Sept. 23, 2010. The new regulations allow consumers to appeal denials either directly to insurers or to external review boards. The rules will not apply to grandfathered plans. Under the new regulations, states are encouraged to adopt the new standards by July 2011. A state that already has an existing external review statute has until July 2011 to adopt the new rules. If, by July 2011 a state has not adopted an external review statute, the plan participant can rely on the federal standard.

Plans not subject to state law, such as self-insured plans, will now be covered by the Federal Internal Appeals and External Appeals standard.

Please be aware that the regulations surrounding this legislation have not yet been finalized. These regulations usually take several months to be drafted and accepted as the intent of this legislation is understood and clarified.

You are receiving this message as courtesy of the SIHO Insurance Services Communications Team. If you have questions or comments specific to newsletter distribution, please contact Chris Asher (Chris.Asher@SIHO.org) or Andrew Kirk (Andrew.Kirk@siho.org). If you wish to be removed from this newsletter, please reply directly to this message asking to ‘unsubscribe’

For past issues and more on health care reform: <http://www.siho.org/en/HCR/>

Follow SIHO on Twitter www.twitter.com/SIHOcares