

On Tuesday, March 23, President Obama signed into law the “Patient Protection and Affordable Care Act” (“PPACA”). A reconciliation bill making changes to the Act was signed by the President on March 30. The PPACA as amended by the reconciliation bill is collectively referred to as the Act in this summary. This summary provides an overview of the product design mandates of the Act.

Effective after 6 Months: The following provisions are effective for plan years beginning on or after September 23, 2010.

Lifetime and Annual Limits (§10101(a)) - Generally, individual and group health plans cannot include lifetime limits or establish unreasonable annual limits on the dollar value of benefits for any participant. Lifetime and annual limits may be imposed on services other than “essential health benefits” (defined below) on an enrollee basis. Until January 1, 2014, plans may also impose annual limits (not lifetime limits) on “essential health benefits,” but only as allowed by the Secretary of HHS.

Prohibition on Rescission (§ 1001 of PPACA adding § 2712 to the Public Health Service Act) - Insurers cannot rescind coverage once the plan has been issued except when the covered individual commits fraud or intentional misrepresentation. Applies to group (fully insured or self funded) and individual markets.

Coverage for Preventative Services (§ 1001 of PPACA adding § 2713 to the Public Health Service Act) – Preventive services must be covered without cost sharing (including deductibles, coinsurance, copayments or other similar charges) in all markets. Preventative services include the following:

- Services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
 - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
 - Evidence-informed preventive care and screenings for infants, children, and adolescents as outlined in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
 - Preventive care and screenings for women as outlined in the comprehensive guidelines supported by the HRSA; and
 - Regarding breast cancer screening, mammography and prevention, the current recommendation of the USPSTF shall control.
- Plans may cover services and screenings in addition to those outlined above.
 - Coverage for the above-referenced services and screenings must, at a minimum, abide by the recommended intervals that the Secretary of HHS shall establish. The intervals set by the Secretary, however, shall not be less than one (1) year.

Coverage for Emergency Services (§ 1001 of PPACA adding § 2719A to the Public Health Service Act) - Individual and group health plans (insured and self funded) must cover emergency services as follows:

- Without the need for any prior authorizations;
- Regardless of whether the provider is in-network; if the provider is out-of-network, the cost-sharing requirement (e.g. co-payment) must be the same as would apply if such emergency services were provided in network; and
- Without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits).

Coverage for Obstetrical or Gynecological Care (§ 1001 of PPACA adding § 2719A to the Public Health Service Act) - Individual and group health plans must provide female participants coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology without the need for any prior authorization and without the need for any referrals.

Expanded Dependent Coverage (§ 1001 of PPACA adding § 2714 to the Public Health Service Act; §§ 1004(d)(3)(B) and 2301 of Reconciliation Bill) - Dependents will be covered to age 26. Dependents may be married or unmarried, but do not include grandchildren. Applies to group (fully insured or self funded) and individual markets. (See BCBSRI's *Federal Healthcare Reform: Dependant Coverage* fact sheet for more information.)

Preexisting Conditions (§ 2301 of Reconciliation Bill) - Individual and group health plans (insured or self funded) cannot impose any preexisting coverage exclusions on coverage for dependants under 19 years old.

Prohibition on Salary-Based Discrimination (§ 10101(d))

- Except for self funded plans, the sponsor of a group health plan may not establish rules relating to health insurance coverage eligibility of any full-time employee based on the hourly or annual salary of that employee. Similarly, plans cannot establish eligibility rules that have the effect of discriminating in favor of higher wage employees.
- Plans may, however, establish lower contribution amounts for employees with lower hourly or annual compensation (i.e. higher compensated employees may contribute more for coverage).

Effective January 1, 2014: The following provisions are effective for plan years beginning on or after January 1, 2014.

Preexisting Conditions (§ 1201 of PPACA adding § 2704 to the PHSA; § 2301 of Reconciliation Bill) - Individual and group health plans (insured or self funded) cannot impose any preexisting coverage exclusions on coverage.

Guaranteed Issue and Renewal (§ 1201 of PPACA adding § 2702 to the PHSA)

- Individual and group health plans (insured or self funded) must accept every employee and individual in the state that applies for coverage. Open and special enrollment periods are permitted. (§ 1201 of PPACA adding § 2702 to the PHSA)
- Individual and group health plans (insured or self funded) cannot establish eligibility rules based on any of the following:
 - Health status;
 - Medical condition (physical and/or mental illness);
 - Claims experience;
 - Receipt of medical care;
 - Genetic information;
 - Evidence of insurability;
 - Disability; or
 - Any other health status-related factor as determined by the Secretary of HHS.(§ 1201 of PPACA adding § 2705 to the PHSA)
- Health insurers must renew or continue individual or group coverage in force until terminated by the individual or plan sponsor. (§ 1201 of PPACA adding § 2703 to the PHSA)

Limitation on Waiting Periods (§ 1201 of PPACA adding § 2708 to the PHSA) - Group health plans cannot apply a waiting period in excess of ninety days.

Essential Health Benefits Package (§1302)

- All individual and small group market insured plans must meet the requirements of the “essential health benefits package” which includes:
 - Coverage for: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health/substance abuse/behavioral health care, prescription drug coverage, rehabilitative services and devices, lab services, preventive/wellness services, chronic disease management, and pediatric services (including oral and vision). These are to be comparable to typical employer plan as certified by CMS and HHS will periodically review the list.
 - Meeting one of four actuarial value tiers (determined by standard population, not plan’s actual population): Bronze (60 percent actuarial value); Silver (70 percent); Gold (80 percent); and Platinum (90 percent). An employer’s HSA contributions may be taken into account in determining the actuarial value. A catastrophic plan can be offered to individuals under the age of 30 or meeting a hardship exemption and a child-only plan can be offered to those up to age 21.
 - Cost sharing limits tied to the HDHP limits, and small group annual deductibles generally are limited to \$2,000/\$4,000.
- The Secretary of HHS shall set forth the scope of “essential health benefits,” which shall be subject public comment.
- Large group health plans must follow the cost sharing limits specified above.

Coverage for Clinical Trial Services (§ 1251 of PPACA; § 2301 of Reconciliation Bill)

- Individual and group health plans:
 - Cannot prohibit an individual from participating in a clinical trial (whether conducted in or out of state);
 - Cannot discriminate against the individual based on their participation in the clinical trial; and
 - Must cover “routine patient care costs” for items and services provided as part of a clinical trial where such items or services consistent with the coverage provided under the plan had the individual not participated in a clinical trial.
- “Routine patient care costs” do not include: investigational items, devices or services; services provided solely to satisfy data collection; or services that are inconsistent with widely accepted standards of care for a particular diagnosis.
- Coverage is restricted to “qualified individuals” who are eligible to participate in the clinical trial for treatment of cancer or other life-threatening diseases and can establish that participation in the program would be beneficial or appropriate.

Note: Coverage in existence at the time of enactment, so-called grandfathered plans, may be exempt from some of the new rating, benefit, and consumer protection rules. (§ 1251 of PPACA; § 2301 of Reconciliation Bill) (See BCBSRI’s *Federal Healthcare Reform: Grandfathering* fact sheet for more information.)

References:

PPACA: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf

Reconciliation: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872pcs.txt.pdf

Quick Reference Guide

Provision	Large Group	Small Group	Self Funded	Individual
Effective Date: October 1, 2010 (plan years beginning on or after September 23, 2010)				
Lifetime Limits	✓	✓	✓	✓
Prohibition on Rescission	✓	✓	✓	✓
Preventative Services Coverage	✓	✓	✓	✓
Emergency Services Coverage	✓	✓	✓	✓
OB/GYN Services Coverage	✓	✓	✓	✓
Dependents Coverage	✓	✓	✓	✓
Salary-based Discrimination	✓	✓		
Preexisting Condition (Dependents under 19 years old)	✓	✓	✓	✓
Effective Date: January 1, 2014 (plan years beginning on or after)				
Preexisting Condition (all enrollees)	✓	✓	✓	✓
Guaranteed Issue and Renewal	✓	✓	✓	✓
Limitation on Waiting Periods	✓	✓	✓	
Essential Health Benefits		✓		✓
Clinical Trial Services Coverage	✓	✓	✓	✓

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