Health Reform Implementation: Immediate Health Insurance Reforms Become Effective

Provision	Summary	Applicability	Effective Date
No Annual or Lifetime Limits	Prohibits the establishment of lifetime limits on the dollar value of essential health benefits for any participant or beneficiary, or annual limits except those defined as "restricted" as determined by the Secretary. The provision for restricted annual limits sunsets with the plan year beginning January 1, 2014. In other words, from January 1, 2014, going forward annual limits will be prohibited in manner similar to lifetime limits. Health plans and health insurance issuers will be permitted to place annual or lifetime limits on specific covered benefits that are not essential health benefits, to the extent that the limits are otherwise permitted by federal and state law. The interim final rule (http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf) was published June 21, 2010.	Lifetime limits apply to all plans; annual limits apply to all plans except grandfathered individual market plans	September 23, 2010
Prohibition on Rescissions	The practice of "rescission" refers to canceling medical coverage after a policyholder has become sick or injured. Rescissions will still be permitted in cases where the covered individual committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. A cancellation of coverage in this case requires prior notice to the enrollee. The interim final rule (http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf) was published June 21, 2010.	Applies to all plans.	September 23, 2010

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Coverage of Preventive Health Services	Non-grandfathered plans are required to provide coverage for preventive health services with no copayments and the service being exempt from deductibles. These preventive services include the following: •services that have in effect a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF) (http://www.ahrq.gov/clinic/pocketgd.htm); •immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) (http://www.immunize.org/acip/); •with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) (http://mchb.hrsa.gov/programs/default.htm); and •with respect to women, such additional preventive care and screenings not described by the USPSTF as provided in comprehensive guidelines supported by HRSA (http://www.hrsa.gov/womenshealth/). A plan or issuer is permitted to cover or deny additional services not recommended by the USPSTF. For the purposes of this provision the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention is considered the most current other than those issued in or around November 2009. The law permits the Secretary to develop guidelines for group health plans and health insurance issuers in the group and individual markets to utilize value-based insurance designs. Value-based insurance designs, as defined in prior testimony before the Senate Committee on Budget, refers to coverage that encourages the use of services that have clinical benefits exceeding the costs, while discouraging the use of services when the expected clinical benefits do not justify the costs. HHS released interim final rules (http://www.healthcare.gov/center/regulations/prevention/regs.html) July 9, 2010. List of recommended services from the Office of Consumer Information and Insurance Oversight (OCIIO) http://www.healthcare.gov/center/regulations/prevention/recommendations.html .	Applies to all non-grandfathered plans.	September 23, 2010

Health Reform Implementation: Immediate Health Insurance Reforms Become Effective

Provision	Summary	Applicability	Effective Date
Extension of Adult Dependent Coverage	Extends coverage to adult children until the individual is 26 years of age. This will not apply to a child of the child receiving dependent coverage. For group plans that are grandfathered, the coverage is limited to those adult children that do not have an offer of coverage from an employer. Interim final rules (http://www.regulations.gov/search/Regs/contentStreamer?objectId=0900006480aeca2b&disposition=attachment&contentType=pdf) were published May 13, 2010. NCSL Fact Sheet (http://www.ncsl.org/documents/health/NCSLDCov.pdf)	Group health plans, a grandfathered plan (includes self insured plans), and a health insurance issuer offering coverage in the group or individual markets that provided dependent coverage.	Effective on the first day of the first plan year that begins on or after September 23, 2010.
Preexisting Condition Exclusion Prohibition for Children under 19 Years of Age	Prohibits health plans from imposing any preexisting condition exclusion enrollees who are under 19 years of age for plan years beginning on or after 6 months from enactment. HHS published the interim final rule (http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf) June 21, 2010.	Group health plans, grandfathered health plans, and health insurance issuers offering group or individual health insurance coverage	September 23, 2010
Prohibition on Discrimination Based on Salary	Sponsors of a group health plan (other than a self-insured plan) is prohibited from establishing rules relating to health insurance eligibility of any full-time employee that are based on the total hourly or annual salary of the employee. In no way will eligibility rules be permitted to discriminate in favor of higher wage employees. The Treasury Department and the Internal Revenue Service (IRS) requested comments September 21, 2010 (http://www.irs.gov/pub/irs-drop/n-10-63.pdf) concerning the application of the rules.	Fully insured non-grandfathered group health plans	Effective for plan years beginning on or after September 23, 2010

Provision	Summary	Applicability	Effective Date
Appeals Process	Requires that a group health plan and a health insurance issuer in the group or individual markets implement an effective appeals process for coverage determinations and claims. The process at a minimum must: •have in effect an internal claims appeals process; •provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable assistance; and •allow an enrollee to review their file, present evidence and testimony and to receive continued coverage pending the outcome. To comply with the requirements, group plans are expected to initially incorporate the claims and appeals procedures set forth at 29 CFR §2560.530-1 and will update their processes in accordance with any standards established by the Secretary of Labor. To comply with the requirements, health insurance issuers offering individual health coverage will provide internal claims and appeals procedures set forth under applicable law and updated by the Secretary of HHS. A group health plan and health insurance issuer offering group or individual coverage must comply with the applicable state external review process that at a minimum includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the NAIC. The plan or issuer is required to implement an effective external review process that meets the minimum standards established by the Secretary if the applicable state has not established standards that meet the NAIC model requirements or if the plan is self-insured and therefore is not subject to state insurance regulation. **OCIIO Information**, http://www.hhs.gov/ociio/regulations/consumerappeals/index.html **Interim Final Rules** were published July 23, 2010, http://edocket.access.gpo.gov/2010/pdf/2010-18043.pdf **Interim Procedures for External Review,** http://www.hhs.gov/ociio/regulations/interim_appeals_guidance_.pdf **National Association of Insurance Commissioners (NAIC) Uniform External Review Model Act** **(http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf)**	All non-grandfathered plans.	Effective for plan years beginning on or after September 23, 2010

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Provision	Summary	Applicability	Effective Date
Patient Protections	**Designation of Primary Care Provider** If a group health plan or health insurance issuer in the group or individual markets requires or provides for designation by a participant, beneficiary or enrollee of a participating primary care provider, then the plan or issuer is required to permit the designation of any participating primary care provider who is available to accept the individual. This same provision **applies for pediatric care** for any child who is a participant, beneficiary, or enrollee of a group health plan or health insurance issuer in the group or individual markets. **Emergency Care Without Prior Authorization** If the group health plan or health insurance issuer in the group or individual markets covers services in an emergency department of a hospital they are required to cover those services without the need for any prior authorization and without the imposition of coverage limitations irrespective of the provider's contractual status with the plan. If the emergency services are provided out-of-network, the cost-sharing requirement will be the same as the cost-sharing for an in-network provider. **OB/Gynecological Care** Patients will also have protected access to obstetrical and gynecological care. HHS published the interim final rule (http://edocket.access.gpo.gov/2010/pdf/2010-14488.pdf) June 21, 2010.	All non-grandfathered plans	Effective for plan years beginning on or after September 23, 2010

"**Grandfathered plan**" refers to a health plan or health insurance coverage in which an individual is enrolled in on the date of enactment (March 23, 2010). Grandfathered plans (1) include plans that are renewed after this date; (2) allow for enrollment of family members, if such enrollment is permitted under the terms of the plan in effect on the date of enactment; and (3) allow for enrollment of new employees (and their families).

Self-insurance refers to coverage that is provided by the organization seeking coverage for its members. Such organizations set aside funds and pay for health benefits directly. (Enrollees may still be charged a premium.) Under self-insurance, the organization itself bears the risk for covering medical expenses. Because self-insured plans are not purchased from an insurance carrier licensed by the state, they are exempt from state requirements and subject only to federal regulation. With fully insured plans, the insurance carrier charges the plan sponsor a fee for providing coverage for the benefits specified in the insurance contract. The fee typically is in the form of a monthly premium. (In turn, the sponsor may decide that each person or family who wishes to enroll must pay part of the premium cost.) Under the fully insured scenario, the private insurer bears the insurance risk; that is, the insurer is responsible for covering the applicable costs associated with covered benefits. Insurance purchased from a state-licensed insurer is subject to both federal and state regulation.

Source: Congressional Research Service reports R40942, and R41069.

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