HealthPlans
A HARVARD PILGRIM COMPANY

Compliance Bulletin
October 6, 2010

Federal Health Care Reform
Implementation of Regulations
Issue Number 3: Mandated Changes – Phase I

This is the third in a series of *Federal Health Care Reform Compliance Bulletin*s that **Health Plans** is issuing as the provisions of the Patient Protection and Affordable Care Act of 2010[1] are implemented. This edition focuses on:

- Coverage for Children to Age 26 Rules released on May 13, 2010[2]
- Preexisting Conditions Exclusions, Lifetime and Annual Limits, Rescissions and Patient Protections Rules released on June 28, 2010; and
- Coverage of Preventive Services Rules released on July 19, 2010

A future *Bulletin* will address new Internal and External Claims and Appeals requirements. Although these provisions were originally scheduled to take effect at the same time as the Rules addressed in this *Bulletin,* the Department of Labor issued a Technical Release on September 20, 2010 that provides a grace period until July 1, 2011 for implementing many of the changes.

Note: *Throughout this* Bulletin*, GF means grandfathered; NGF means non-grandfathered*

Inside

How to use this *Bulletin*:

- If your plan(s) are grandfathered, they must incorporate the provisions described on pages 2-7
- If your plan(s) are non-grandfathered, they must incorporate all the provisions described on pages 2-11
- Use the *Rules Implementation Reference Chart* for information about the actions that **Health Plans** will take and you need to take to implement the provisions described in this *Bulletin*
- Use the *HCR Mandated Notice Reference Chart* to determine which notices you will need to distribute and when
- Adapt the attached *Model Notices* applicable to your plan and distribute accordingly, and adapt the suggested text for rescissions if your plan needs to rescind coverage in the future
- Refer to the *Grandfathering Provisions Chart* for an overview of the mandated provisions which apply to your plan and when

[1]Retiree-only and HIPAA excepted benefit plans (i.e., stand-alone dental and visions plans, and flexible spending account plans) are exempt from the health plan reform mandates of federal health care reform. As such, these plans are not subject to the Rules described in this *Bulletin*.
[2]Although this topic was discussed in depth in the first *Bulletin*, implementation dates coincide with the mandates discussed in this issue. As such, we have included this information again.

Provisions Applicable to All Plans

These provisions must be incorporated into GF and NGF plans by the first day of the first plan year that begins on or after September 23, 2010.

Coverage of Children to Age 26 (for GF plans only)[3]

GF plans that cover dependent children must extend coverage for children to age 26, with one exception:

> If the child has coverage available through another employer group health plan, other than a plan offered by the employer of a parent, the plan is not required to extend eligibility to that child.
>
> This exception applies only until the earlier of the date the plan becomes NGF or the first plan year that begins on or after January 1, 2014. Otherwise, the plan may not condition eligibility on any other factor such as tax, marital or student status.

Note: In May 2010, the IRS and DOL requested that plans implement this rule in advance of the mandate to avoid creating breaks in coverage for dependents who would lose eligibility before the extended coverage mandate took effect. If your plan has been amended to permit children under age 26 to enroll, there is no need for further action on this provision. However, if your plan was amended only to continue coverage for children already enrolled and did not provide a new enrollment opportunity, or if your plan has not been amended at all for this provision, the requirements described below will apply.

- **Notice Requirement**

  Plans must notify all eligible employees that:
  - ◊ Children under age 26 are eligible to enroll
  - ◊ A 30-day special enrollment period will be available to allow children to enroll

  The notice may be provided to employees on behalf of their dependents and may be included with other enrollment materials distributed by the plan, provided the notice is prominent. A copy of the DOL Model Notice which may be used to satisfy these requirements is attached with this *Bulletin*.

- **Special Enrollment Period**

  The 30-day special enrollment period may coincide with the plan's usual open enrollment period provided it is at least 30 days long and employees are notified in advance. Coverage for those who elect to participate during the special/open enrollment period must be effective no later than the first day of the first plan year after September 23, 2010.

  The enrollee must be treated as a HIPAA special enrollee and offered all benefit packages available to similarly situated individuals who did not lose coverage. If the enrollee is not the employee, the employee is also eligible to enroll or change benefit options during the special/open enrollment period.

[3]Note that the requirements for coverage of children to age 26 varies depending on whether the plan is GF or NGF. Please see *Additional Provisions Applicable Only to NGF Plans*, page 8, for the rule applicable to NGF plans.

Coverage of Children to Age 26 (for GF plans only), *cont'd*

- **Eligibility under Dental and Vision Plans**

  For ease of administration and to maintain consistent criteria for dependent eligibility across all group health plans, we will assume that our clients want to apply the extension of coverage to age 26 to any stand-alone dental or vision plans[4] that **Health Plans** administers, even though it is not required (unless a client informs us otherwise).

Preexisting Condition Exclusions

- Plans may not limit or exclude coverage for benefits related to a preexisting condition for any individual under age 19.[5]
- Any exclusionary period that applies at the time the new rule goes into effect must end and coverage for the preexisting condition must be immediately provided (e.g., if a dependent child with a preexisting condition enrolled effective October 1, 2010 into a plan operated on a calendar year basis, and is subject to a 12 month exclusionary period, the exclusion must end on January 1, 2011).

Lifetime and Annual Limits

- **Lifetime Limits**
  - ◊ Plans may not impose lifetime dollar limits on "essential health benefits" (EHBs) (see *About Essential Health Benefits*, page 4). Lifetime dollar limits are allowed on non-essential benefits.
  - ◊ **Notice Requirement**
    Plans must notify individuals who have reached the lifetime limit that:
    - ♦ Lifetime limits no longer apply,
    - ♦ They have regained eligibility for benefits under the plan, and
    - ♦ Anyone no longer enrolled in the plan due to reaching the lifetime limit will have a 30-day special enrollment period.

    The notice may be provided to employees on behalf of their dependents and may be included with other enrollment materials distributed by the plan, provided the notice is prominent. A copy of the DOL Model Notice which may be used to satisfy these requirements is attached with this *Bulletin*.
  - ◊ **Special Enrollment Period**
    The 30-day special enrollment period may coincide with the plan's usual open enrollment period provided it is at least 30 days long and employees are notified in advance. Coverage for those who elect to participate during the special/open enrollment period must be effective no later than the first day of the first plan year after September 23, 2010.

    The enrollee must be treated as a HIPAA special enrollee and offered all benefit packages available to similarly situated individuals who did not lose coverage. If the enrollee is not the employee, the employee is also eligible to enroll or change benefit options during the special/open enrollment period.

[4]A "stand-alone" dental or vision plan provides coverage that is not included when a member elects coverage in a medical plan, but rather must be elected separately.
[5]In the future, preexisting conditions exclusion limitations must be removed for all individuals, but not until plan years beginning on or after January 1, 2014.

Lifetime and Annual Limits, *cont'd*

- **Annual Limits**

  Except as described below, plans may not impose any annual dollar limits on "essential health benefits" (EHBs) (see *About Essential Health Benefits*, below). Annual dollar limits are allowed on non-essential benefits. Until January 1, 2014, plans may impose restricted overall annual dollar limits on EHBs in the amounts shown below:

Plan years that begin on or after:	But before:	May adopt an annual dollar limit no less than:
September 23, 2010	September 23, 2011	$ 750,000
September 23, 2011	September 23, 2012	$1,250,000
September 23, 2012	January 1, 2014	$2,000,000

  No annual dollar limits are permitted for plan years that begin on or after January 1, 2014.

  Note: A plan may convert an overall lifetime dollar limit to a restricted overall annual dollar limit described above. However, if a plan applies a restricted overall annual dollar limit which is lower than the overall lifetime dollar limit in effect on March 23, 2010, the plan will lose grandfathered status. (See **Health Plans**' *Grandfathering Checklist* provided with our August 20, 2010 *Compliance Bulletin Issue Number 2: Grandfathering Provisions*.)

- **About Essential Health Benefits**

  The Rules define "essential health benefits" (EHBs) as including at least the following general categories and the items and services covered within the categories:

  ◊ Ambulatory patient services
  ◊ Emergency services
  ◊ Hospitalization
  ◊ Maternity and newborn care
  ◊ Mental health and substance abuse disorders, including behavioral health treatment
  ◊ Prescription drugs
  ◊ Rehabilitative and habilitative services and devices
  ◊ Laboratory services
  ◊ Preventive and wellness services and chronic disease management; and
  ◊ Pediatric services (including pediatric oral and vision care)

  The categories are very broad and are not currently further defined by regulation. The implementing federal agencies are required to issue regulations with more detailed definitions, but have no specific deadline to do so.

  In the meantime, the Rules require a consistent "good faith effort" to comply with a "reasonable interpretation" of the term EHB which **Health Plans** has undertaken on our clients' behalf.

  Here is a summary of **Health Plans'** approach with respect to categorizing EHBs and non-EHBs:

  Most benefits covered under our clients' plans, such as in- and out-patient physician care, in- and out-patient hospital services, and diagnostic and laboratory services, clearly fall into one or more of the categories listed above and, as such, must be treated as EHBs.

  Non-essential health benefits have been categorized as those which 1) do not obviously fit under the general classifications specified under the regulations, or 2) have not traditionally been offered under a majority of our clients' plans. These include items and services which either represent an alternative to traditional medical care (e.g., chiropractic services, biofeedback, and massage therapy) or have a quasi- or non-medical basis (e.g., fitness reimbursements, marital counseling and non-medical travel expenses).

Lifetime and Annual Limits, About Essential Health Benefits, *cont'd*

When the implementing regulations with detailed definitions are issued, we may find that some services currently categorized as non-essential will have to be included with the EHBs. Until then, **Health Plans** will apply our determinations of EHBs across all plans to administer our clients' plans in accordance with our understanding of the current Rules.

Your **Health Plans** Account Manager will discuss EHBs in relation to your specific plan design with you, answer any questions you may have related to our categorization of EHBs and help you to identify any dollar limits that will need to be removed.

> **IMPORTANT: EHBs are *Not* Mandated Benefits**
> EHBs are the types of benefits that must be provided through the Exchanges in 2014, but they are **NOT** coverage mandates for employers. Instead, they are those benefits which, if covered under a plan, may not have any annual or lifetime dollar limits. Plans may continue to exclude "all benefits for a condition" (although such exclusions may be limited by other state or federal laws), but if benefits are provided for services which are EHBs, neither annual nor lifetime dollar limits may be applied**.**

- **Other Considerations Regarding Benefit Limits**
  - ◊ **Non-Dollar and Network Limits**
    The Rules do not prohibit specific treatment limits (such as day or visit limits). Such specific treatment limits may not apply to mental health and substance abuse benefits, however, due to the federal mental health parity act. The annual and lifetime limits sections of the Rules do not distinguish between in-network and out-of-network benefits and, as such, the restrictions on annual and lifetime limitations apply to both in-network and out-of-network coverage levels.
  - ◊ **Account-Based Plans**
    The new lifetime and annual limit rules do not apply to:
    - ♦ Health flexible spending accounts (FSA);
    - ♦ Health savings accounts (HSA); and
    - ♦ Health reimbursement arrangements (HRA) that are integrated with other coverage, where the other coverage alone complies with the lifetime/annual limit requirements.

Federal Health Care Reform
Implementation of Regulations
Issue Number 3: Mandated Changes – Phase I

Rescissions

- Plans may not rescind (retroactively terminate) a participant's coverage except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan.
- A "rescission" does not include a retroactive termination for failure to pay premiums in a timely manner or a prospective termination of coverage.
- Coverage cannot be rescinded for inadvertent nondisclosures by an employee or dependent regarding his/her eligibility for coverage under a plan.

- **Implications**
  - Retroactive terminations of coverage due to employer mistake, such as when the employer overlooks an employee's or dependent's change in status, are no longer allowed. This example is from the regulations:

    > An employee is covered as full-time, but is reassigned to a part-time position and therefore loses eligibility for coverage. The employer mistakenly continues to provide coverage and later discovers through a routine audit that the employee is no longer considered full-time. The employer cannot rescind coverage to the date the employee became part-time since there was no fraud or misrepresentation of a material fact by the employee. Coverage may, however, be terminated on a prospective basis.

  - Since coverage can be rescinded only due to fraud or intentional misrepresentation of material fact and not for inadvertent nondisclosures, it may be difficult for an employer to prove intent on the part of participants who simply fail to disclose information.
  - The regulations are not clear regarding retroactive termination under the COBRA rules.
    - Once a participant has a COBRA qualifying event, the COBRA rules allow a plan to continue coverage during the COBRA election period and retroactively terminate the coverage back to the qualifying event date if the participant never elected or paid for COBRA coverage. The rescission rules do not address whether such retroactive terminations are still allowed.

      However, because retroactive termination is permitted for non-payment, until further regulations are issued, **Health Plans** will continue to administer COBRA coverage under pre-health care reform procedures if we administer COBRA for your plan.

    - If a participant's coverage is inadvertently continued after what would otherwise be a COBRA qualifying event (e.g., an employee's termination of employment or a dependent ceases to be eligible under the terms of the plan), the rescission rules do not allow the plan to terminate coverage retroactive to the date of the qualifying event. However, it is not clear whether the plan may at least credit the period of inadvertent coverage toward satisfaction of the maximum number of months of COBRA continuation coverage that must be provided (i.e., 18, 29 or 36 months depending upon the type of qualifying event).

      Again, in the absence of clear direction from the implementing agencies, **Health Plans** will continue to count any period of inadvertent coverage toward an individual's maximum coverage period under COBRA, if we administer COBRA for your plan.

- **Notice Requirement**
  - Plans must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded.
  - The notice must provide the participant with an opportunity to appeal the determination.

Rescissions, *cont'd*

- ***Implementation Note Regarding Rescissions:***

  ◊ **Health Plans** will amend your plan to include:
  - ♦ Provisions regarding the rescission rules in order to preserve the plan's ability to retroactively terminate coverage in the event of fraud or material misrepresentation; and
  - ♦ Language regarding the employee's responsibility to notify the plan of any changes in a dependent's status.

  ◊ As the Plan Sponsor, you will need to:

  - ♦ Ensure that member terminations are administered in accordance with the rescission rules which do not allow retroactive terminations of coverage except in cases of fraud or intentional misrepresentation of material fact, keeping in mind:
    - ▪ It may be difficult to prove fraud or intentional misrepresentation;
    - ▪ You cannot retroactively terminate a member due to administrative error (i.e., you mistakenly continue to provide coverage to an otherwise ineligible member); and
    - ▪ You may make retroactive terminations for untimely payment of premiums.
  - ♦ Provide 30 days advance written notice to each member affected by the rescission with an opportunity to appeal the determination.

    Note: While the DOL has issued a new *Model Notice of Adverse Benefit Determination* in connection with the new Claims and Appeals requirements (i.e., requirements for new content in EOBs), which is to be used and adapted for rescissions, plans have a grace period until July 1, 2011 to implement and issue the new model form EOB. However, there is no grace period for notices of rescission. As such, until further guidance is received from the DOL regarding model rescission notices to be implemented prior to July, 1 2011, **Health Plans** has drafted the suggested text attached with this *Bulletin* which you may adapt to notify members of rescissions.
  - ♦ Continue to notify **Health Plans** regarding the eligibility of each plan participant in a timely manner. When we receive eligibility and termination information, **Health Plans** will assume that you are properly administering terminations under the new rules, and that you have provided the required 30 days notice to members if coverage is rescinded.

Additional Provisions Applicable Only to Non-Grandfathered (NGF) Plans

In addition to the Rules that apply to all plans (see pages 2-7), the following provisions must also be incorporated into all NGF plans by the first day of the first plan year that begins on or after September 23, 2010.

Note: If a plan becomes NGF after the first plan year that begins on or after September 23, 2010, the NGF provisions must be implemented as of the date the plan becomes NGF.

Coverage of Children to Age 26, with no exceptions

NGF plans that cover dependent children must extend coverage for children to age 26, without regard to any other factor including tax, marital, student or employment status, or the availability of other employer-sponsored group health coverage.

Note: In May 2010, the IRS and DOL requested that plans implement this rule in advance of the mandate to avoid creating breaks in coverage for dependents who would lose eligibility before the extended coverage mandate took effect. If your plan has been amended to permit children under age 26 to enroll without any restriction regarding the availability of other coverage, there is no need for further action on this provision. However, if your plan was: a) amended only to continue coverage for children already enrolled and did not provide a new enrollment opportunity, b) amended but continues to exclude coverage for adult children who have other employer-sponsored coverage available, or c) has not been amended at all for this provision, the requirements described below will apply.

- **Notice Requirement**

  Plans must notify all eligible employees that:
  - ◊ Children under age 26 are eligible to enroll
  - ◊ A 30-day special enrollment period will be available to allow children to enroll

  The notice may be provided to employees on behalf of their dependents and may be included with other enrollment materials distributed by the plan, provided the notice is prominent. A copy of the DOL Model Notice which may be used to satisfy these requirements is attached with this *Bulletin*.

- **Special Enrollment Period**

  The 30-day special enrollment period may coincide with the plan's usual open enrollment period provided it is at least 30 days long and employees are notified in advance. Coverage for those who elect to participate during the special/open enrollment period must be effective no later than the first day of the first plan year after September 23, 2010.

  The enrollee must be treated as a HIPAA special enrollee and offered all benefit packages available to similarly situated individuals who did not lose coverage. If the enrollee is not the employee, the employee is also eligible to enroll or change benefit options during the special/open enrollment period.

- **Eligibility under Dental and Vision Plans**

  For ease of administration and to maintain consistent criteria for dependent eligibility across all group health plans, we will assume that our clients will want to apply the extension of coverage to age 26 to any stand-alone dental or vision plans[6] that **Health Plans** administers, even though it is not required (unless a client informs us otherwise).

[6] A "stand-alone" dental or vision plan provides coverage that is not included when a member elects coverage in a medical plan, but rather must be elected separately.

Federal Health Care Reform
Implementation of Regulations
Issue Number 3: Mandated Changes – Phase I

Coverage of Preventive Services

The Rules are designed to help make wellness and preventive services affordable and accessible by requiring plans to cover a wide array of recommended preventive services **in-network** with no member co-payments, coinsurance or deductibles. Under the Rules, patients will have easier access to services such as blood pressure, diabetes, and cholesterol tests; many cancer screenings; counseling from health care providers on such topics as quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use; routine vaccinations; flu and pneumonia shots; pre-natal care; and regular wellness visits for infants and children.

- **Recommended Preventive Services**

  The Rules draw on multiple federal government sources to identify the mandated preventive services. Most, such as routine physicals, mammograms, colorectal cancer screening (colonoscopies and sigmoidoscopies), routine gynecological exams, and immunizations for children and adults are currently covered by our clients' plans. However**,** there are several items included on the lists of required services that are not typically or generally provided, including:

  ◊ Fluoride supplements for pre-school children*
  ◊ Folic acid supplements for pregnant women*
  ◊ Nutritional counseling to prevent disease
  ◊ Smoking cessation counseling for tobacco users
  ◊ Osteoporosis screening for women age 60 and older

  *These items will be covered when filled through the prescription drug benefit.

  HealthCare.gov includes all the specific recommendations and guidelines adopted by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC Advisory Committee), and Health Resources and Services Administration (HRSA) that must be covered by NGF plans, as well as the applicable frequency and age ranges. This website will regularly be updated to reflect changes to recommended items or services.

  Your **Health Plans** Account Manager will work with you to identify which changes will be required to your current coverage of preventive services.

- **Out-of-Network Coverage not Required**

  The coverage requirements for preventive care apply only to in-network services. The Rules do not apply to preventive services rendered by out-of-network providers. As such, if a plan covers the services out-of-network, it may impose co-payments, coinsurance, and deductibles. In addition, plans may exclude the recommended preventive services from out-of-network coverage altogether.

- **Permitted Cost Sharing**

  ◊ **Preventive Services not Recommended**
  Plans may impose cost-sharing for any in-network preventive services not required to be covered, (e.g., routine vision exams for members over age 5).

  ◊ **Frequency, Method, Treatment or Setting Limitations**
  If a recommendation for a preventive care item or service does not specify the frequency, method, treatment, or setting for the service, the plan may use "reasonable medical management techniques" to determine any coverage limitations (e.g., limit routine colonoscopies to one annually).

  ◊ **Treatment for Conditions Diagnosed Through Preventive Services**
  Plans may impose cost-sharing for the treatment of conditions diagnosed as a result of one of the recommended preventive services (e.g., if a member's colonoscopy reveals that the member has colon cancer, the plan may require cost-sharing for cancer treatments but not for the initial colonoscopy).

Coverage of Preventive Services, *cont'd*

- **Effective Date and Future Changes to Recommended Services**

  NGF plans must cover the recommended preventive services effective plan years beginning on or after September 23, 2010. The list of recommended services may be subject to change and plans are required to incorporate such changes the first plan year after the recommendation has been in effect for 12 months.

  If a recommended service is dropped from the list, plans are no longer required to provide the service (subject to other state or federal requirements and notice obligations regarding the elimination of coverage).

  Health Plans will notify our clients in the event that any services are either added to or deleted from the list.

Patient Protections

The Rules provide that participants have the right to:

- Choose their health care providers in plans with networks of plan providers
- Receive coverage for emergency services without prior authorization and at in-network levels without regard to whether the provider is in-network or out-of-network

- **Choice of Provider**

  For plans which require or provide for the designation of a primary care provider (PCP), the rules described below apply.

  Note: The vast majority of our clients' plans do not require PCP designation. If your plan does not have PCP requirements, these Choice of Provider Rules **do not apply**.

  - **Primary Care Provider or Pediatrician**
    Participants must be allowed to designate any participating PCP who is available to accept new patients. A plan may designate a default PCP until the participant has designated his/her own (i.e., the plan may designate a PCP for participants who enroll without choosing a PCP). For a child, the plan must allow any participating pediatrician who is available to accept new patients to be designated as the PCP.
  - **OB/GYN**
    A plan cannot require any preauthorization or referral to access any participating OB/GYN provider. A plan may require the provider to adhere to the plan's rules regarding further referrals or authorizations, and may require the participant to notify their PCP or obtain precertification from the plan regarding procedures which require such precertification under the terms of the plan.
  - **Notice Requirement**
    NGF plans must provide participants with a notice of the choice of provider rules. The Rules require the notice to be provided with the summary plan description or other similar description of benefits under the plan no later than the first day of the first plan year beginning on or after September 23, 2010. However, the notice should be distributed with other enrollment materials regardless of whether a summary plan description or other benefits description is issued at the same time. The DOL Model Notice which may be used to satisfy these requirements is attached with this *Bulletin*.

- **Emergency Services**

  For emergency services (as defined under the Rules), the following provisions apply:

  - Prior authorization cannot be required for emergency care regardless of whether the services are rendered in-network or out-of-network.
  - Copayment and coinsurance for out-of-network emergency services cannot exceed the copayment and coinsurance requirements for in-network emergency services.

Patient Protections, Emergency Services, *cont'd*

- ◊ Deductibles and out-of-pocket maximums may apply to out-of-network emergency services and may exceed the in-network requirements, but only if the out-of-network deductibles and out-of-pocket maximums generally apply to all out-of-network benefits (not just to emergency services).
- ◊ Out-of-network providers may balance bill patients any excess over the amount the plan is required to pay, but only if the plan pays an amount equal to the greatest of the following:
  - ♦ The median of all negotiated in-network provider rates for emergency services furnished;
  - ♦ The out-of-network payment rates (e.g., usual and customary rates) for emergency services; or
  - ♦ The amount that would be paid under Medicare (Part A or Part B) for emergency services.

  These amounts exclude any in-network copayments and coinsurance that the participant would be responsible for if the services had been provided in-network.

  Since out of network ER services under our clients' plans are paid at usual and customary levels (unless a specific case rate is otherwise negotiated), the plan will be deemed to pay a reasonable amount that is equal to or greater than the three amounts prescribed under the Rules (i.e., U&C levels will, in most cases, be higher than in-network negotiated rates and Medicare payment rates). Out-of-network providers will be able to balance bill the difference between billed charges and the U&C reimbursement.

Implementation

Please see the *Rules Implementation Reference Chart* on page 12 which identifies all the actions that **Health Plans** will take and you will need to take to implement the mandated provisions addressed in this *Bulletin*. Please also see additional detail regarding implementation of the rescission provisions on page 7.

As additional health care reform regulations are issued and analyzed, future editions of our *Implementation of Regulations* series will provide in-depth reviews of provisions that will affect our clients' plans. In the meantime, if you have questions about your plans, please contact your **Health Plans** Account Manager.

Special Note Regarding Medicaid

Health Plans was recently contacted by Health Management Systems, Inc. (HMS) requesting that we participate in eligibility file exchanges on behalf or our clients. HMS contracts with state Medicaid programs to perform recovery services in relation to payments made by Medicaid for which a third party, such as an employer group health plan, should have been the primary payer. Medicaid is the payer of last resort and should pay for services only after all other healthcare coverage is exhausted.

HMS cross matches eligibility files from Medicaid, health insurers and third party administrators to identify any overlapping beneficiaries and coverage. When HMS identifies a Medicaid beneficiary as having other primary coverage, they report the information to Medicaid and undertake post-payment recovery from the primary payer.

We were not required to provide eligibility data to Medicaid until it was officially requested. Now that it has been, **Health Plans** must provide the data as required under state and federal law. Accordingly, we will submit your plan's eligibility files to HMS to determine if any services covered for Medicaid beneficiaries should have been paid by your plan as the primary payer. As required, we will submit eligibility files covering the 36 months immediately preceding our first data submission (expected in 4-6 weeks), with monthly updates thereafter. Please note that sharing clients' eligibility files for this purpose is expressly permitted under HIPAA.

Please contact your **Health Plans** Account Manager with any questions you may have.

This Bulletin *is intended to provide a summary of our understanding of significant developments which may affect our clients' plans. It should not be construed as specific legal advice or legal opinion. The contents are for general informational purposes only and are not a substitute for the advice of legal counsel.*

RULES IMPLEMENTATION REFERENCE CHART

Sample Model Notices were attached with the email transmitting this Bulletin:
- Elimination of Lifetime Limits
- Coverage for Children to Age 26 (GF and NGF)
- Grandfathering Statement
- Choice of Provider
- Suggested text for rescission notices

	ACTION ITEMS					
	Health Plans draft amendments	**Health Plans** implement coverage changes	**Health Plans** Acct Mgr and **Plan Sponsor** consult on impact/other changes	**Plan Sponsor** distribute mandated notices*	**Plan Sponsor** hold special enrollment period*	**Plan Sponsor** confirm internal procedures to ensure compliance
PROVISIONS						
All Plans: GF and NGF						
• **Remove pre-existing condition limitations for members under age 19**	✓	✓				
• **Remove lifetime dollar limits on EHBs**	✓	✓	✓	✓	✓	
• **Remove annual dollar limits on EHBs**	✓	✓	✓			
• **Apply rescissions provisions**	✓					✓
GF Plans Only						
• **Provide coverage to age 26, unless non-parent ER coverage available**	✓	✓		✓	✓	
• **Include Grandfathering Statement on all plan materials**	✓			✓		
NGF Plans Only						
• **Provide coverage to age 26, no exceptions for other coverage**	✓	✓		✓	✓	
• **Allow choice of provider for plans that require designation of PCP**	✓	✓		✓		
• **Cover emergency services without preauthorization at in-network levels**	✓	✓				
• **Cover mandated preventive services at 100% in-network**	✓	✓	✓			

* The notices and special enrollment periods required for the mandated provisions may be combined with open enrollment materials and may coincide with the open enrollment period if:
- The mandated messages are prominently displayed in the open enrollment materials
- The open enrollment period lasts for at least 30 days after employees are notified
- Elections for coverage are effective no later than the first day of the first plan year that begins on or after September 23, 2010, even if the elections were made after that date due to the open enrollment extending beyond that date

HCR MANDATED NOTICE REFERENCE CHART

Mandated notices that employers must distribute in addition to plan amendments.

Employers may combine the notices* regarding the mandated special enrollment periods with their other annual enrollment materials if:

- The mandated notices are prominently displayed,
- The annual enrollment period runs for at least 30 days following distribution of the mandated notice, and
- The effective date of coverage elected during the special enrollment period is no later than the first day of the first plan year that begins on or after September 23, 2010.

	AUDIENCE – DISTRIBUTION METHOD		
	Special 30-day open enrollment notice to ALL EMPLOYEES*	**Distribute to individuals as applicable**	**Include with materials describing plan benefits***
NOTICE CONTENT			
Lifetime dollar limits on EHBs will be removed • Members who previously reached lifetime limit will regain coverage or may re-enroll • Employee may re-enroll in any option or change coverage levels if s/he or dependent previously reached lifetime limit	✓- All Plans		
Provide coverage to age 26, unless non-parent employer coverage available • Any child under 26 without non-parent employer group health coverage may now enroll • Employee may re-enroll in any option or change coverage levels when child enrolls	✓- GF Plans only		
Provide coverage to age 26, no exceptions for other coverage • Any child under 26 may now enroll • Employee may re-enroll in any option or change coverage levels when child enrolls	✓- NGF Plans only		
Grandfathering statement			✓- GF Plans only
Provide 30-days advance notice for rescissions		✓- All Plans	
Allow choice of provider for plans that require PCP designation			✓- NGF Plans only

* Employers may adapt and use the DOL Model Notices attached with this *Bulletin* to satisfy these requirements. Note: The Rescission Notice is not a DOL model; rather it is suggested language developed by **Health Plans** which employers may adapt accordingly.

GRANDFATHERING PROVISIONS REFERENCE CHART

PROVISIONS IN BOLDFACE APPLY TO NON-GRANDFATHERED PLANS ONLY

No.	EFFECTIVE DATE	PROVISION	GF	NON-GF
1.	March 30, 2010	▶Change in definition of dependent for purposes of tax free health coverage*	✓	✓
2.	Effective date currently unknown; TBD in regulations	▶Automatic enrollment^	✓	✓
3.	First plan year beginning on or after September 23, 2010	▶Elimination of preexisting conditions exclusions for enrollees under age 19*	✓	✓
		▶Restricted annual dollar limits on essential health benefits**	✓	✓
		▶No lifetime dollar limits on essential health benefits**	✓	✓
		▶Prohibition on rescissions (cancellations) of coverage*	✓	✓
		▶All plan materials distributed to participants must contain notice re: grandfathering*	✓	
		▶Extension of coverage for children to age 26, unless other employer coverage available*	✓	
		▶Extension of coverage for children to age 26 (no exception for other coverage)*		✓
		▶100% coverage with no cost-sharing for in-network preventive care*		✓
		▶Expanded internal appeals process (more than current ERISA/DOL)*		✓
		▶Allow individuals to choose pediatrician or OB/GYN as PCP*		✓
		▶Allow ER services w/o pre-authorization and cover as in-network*		✓
4.	Starting with 2011 W-2	▶W-2 Reporting on value of health benefits^	✓	✓
5.	March 2012	▶Standardized benefit summaries (by March 23, 2012)^	✓	✓
		▶Advance notice of plan changes – 60 days in advance of effective date^	✓	✓
		▶Administrative simplification provisions (varying effective dates beginning in 2012)^	✓	✓
		▶Reporting requirements regarding quality of care^		✓
6.	Plan years ending after September 30, 2012	▶Comparative effectiveness fee based on average covered lives^	✓	✓
7.	January 2014	**▶Reporting requirements regarding transparency data^**		✓
8.	First plan year on or after January 1, 2014	▶No annual dollar limits on essential health benefits**	✓	✓
		▶Elimination of preexisting conditions exclusions for all enrollees*	✓	✓
		▶Waiting periods limited to 90 days^	✓	✓
		▶Extension of coverage for children to age 26 (no exception for other coverage)*	✓	✓
		▶Maximum limits on deductibles, coinsurance and copayments^		✓
		▶Coverage required for routine costs of patients in clinical trials^		✓
9.	January 1, 2018	▶Cadillac plan tax^	✓	✓

* Implementing regulations have been issued

** Implementing regulations have been issued which do not address all aspects of the provision; more guidance should be forthcoming

^ Subject to implementing regulations