

HEALTH REFORM **IMPACT**

What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

Coverage Provision Changes: Private Insurers Should Start Planning Now

June 10, 2010

Changes to the insurance industry are a significant focus of the health reform legislation¹ enacted earlier this year. Private insurers currently face mandated alterations of coverage, with implementation spread across many years. However, even changes not required until 2014 may require careful consideration and planning now to allow sufficient time for actuarial analysis, premium rate calculation, policy form revision, and filing and approval of rates and forms with applicable state insurance regulators. While group health plans in existence as of March 23, 2010 are "grandfathered out" of many of these timeframes, insurers must be careful to understand the requirements for grandfathered status, as well as be aware that most of the provisions regarding grandfathered plans simply delay, rather than eliminate, the coverage requirements. Below is an implementation timeline describing the changes required for coverage under the Act.

Required for plan years beginning after September 22, 2010 (for plans that run with the calendar year, these changes will be mandatory on January 1, 2011):

Expansion of Dependent Coverage to Age 26.² Any insurance plan that offers dependent coverage of children must make that coverage available to any child under the age of 26 regardless of the child's marital or student status, financial situation or location. Recent regulations make clear that this expansion includes dependents who were never offered coverage due to age as well as those who have "aged out" of their coverage.

Expansion of Coverage Limits and Limitations on Exclusions.³ Insurers may not discriminate based on the wages of employees. In addition, both new policies and grandfathered plans are (1) not allowed to rescind policies already issued (except in cases of fraud), (2) are prohibited from setting lifetime limits on coverage and (3) will be able to set annual limits on coverage only as

¹ The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act") was signed into law, in final form, on March 30, 2010.

² Please see two previous issues of Health Reform IMPACT: "IRS Issues Guidance Permitting Group Health Plans to Eliminate Potential Coverage Gap for Adult Children" (May 5, 2010); and "New Regulations Expand Dependent Coverage to Children Under Age 26" (May 17, 2010), available at www.bassberry.com/healthreformimpact.

³ Please see two previous issues of Health Reform IMPACT: Grandfathered Health Plans – Significant Exemptions From Health Reform Legislation (April 7, 2010); and "Existing Health Plans - Changes Requiring Attention this Year" (April 8, 2010), available at www.bassberry.com/healthreformimpact.

determined by the regulations to be issued by the Department of Health and Human Services ("HHS"). The Act prohibits insurers from excluding coverage based on pre-existing conditions for children up to age 19 (prohibitions related to adults become effective in 2014).

New Benefit Mandates. All plans must include preventative services and immunizations and may not impose any cost-sharing measures for these services. The Act ties applicable preventative services to those recommended by the U.S. Preventative Services Task Force, immunizations as called for by the Centers for Disease Control and Prevention, and preventative care and screenings for children and women as described in the guidelines of the Health Resources and Services Administration. HHS is to determine the timeframe between the change of any of these guidelines and their required inclusion by health insurance plans, but the Act sets the minimum interval at one year.

Limits on Managed Care Controls. Insurers may no longer require insurance authorization prior to treatment for emergency services or obstetric and gynecological care. Emergency services given by providers who are not contracted with the plans cannot have any additional coverage limitations nor can additional cost sharing be imposed on the enrollee for such services. Similarly, where insurers require designation of a primary care physician, enrollees must be able to choose any participating primary care provider.

Required beginning January 1, 2014:

Prohibitions on Coverage Limits and Exclusions. The Act prohibits insurers from excluding coverage based on pre-existing conditions for adults as well as children. Insurers may not discriminate based on medical history or condition (both mental and physical), health status, genetic information, disability, or claims experience, or any other factor set forth by HHS. Insurers will be required to issue and renew health insurance coverage to everyone who applies for coverage, and waiting periods for coverage in both large and small group plans may not exceed 90 days (including grandfathered plans). In addition, plans will be prohibited from setting annual limits on the amount of coverage an individual may receive. For enrollees participating in a clinical trial, health plans will be required to cover routine care and retain coverage of the enrollees.

New Benefit Mandates. All qualified health plans (as health plans must be designated to participate in the state insurance exchanges) must provide the "essential health benefits package." While HHS will define the specifics of this package, the Act requires the following general categories to be addressed: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health; prescription drugs; rehabilitation; laboratory services; preventative and wellness services; and chronic disease management and pediatric services, including dental and vision.

In addition to these coverage changes, the Act institutes a number of premium requirements and limitations, notice and administrative mandates, and reporting requirements. These provisions will be described in later issues of Health Reform IMPACT. If you have questions regarding the information in this issue, or with respect to other provisions of the health reform legislation as it relates to your insurance industry and operations, please contact any of the attorneys in our Insurance and Managed Care Practice Group listed below.

Also, please [click here](#) to visit our special Web page for Health Reform IMPACT.

Bass, Berry & Sims Insurance and Managed Care Attorneys

Elisa Harris
(615) 742-6553
eharris@bassberry.com

T. Scott Noonan
(615) 742-6273
snoonan@bassberry.com

Elizabeth S. Warren
(615) 742-7719
ewarren@bassberry.com

Angela Humphreys
(615) 742-7852
ahumphreys@bassberry.com

T. Stephen C. Taylor
(615) 742-7758
staylor@bassberry.com

Robins H. Ledyard
(615) 742-6259
rledyard@bassberry.com

Bob F. Thompson
(615) 742-6262
bthompson@bassberry.com

The materials contained herein have been abridged from the statutory sources and should not be construed or relied upon for legal advice. Readers are urged to consult legal counsel concerning particular situations and specific legal questions.

To ensure compliance with requirements imposed by the IRS, we inform you that this message is not intended to be used, and cannot be used, by the addressee or any other person for the purpose of avoiding penalties that may be imposed under the Internal Revenue Code.