

## Overview of Immediate Impact Health Care Reform Provisions: The Senate and House-Passed Patient Protection and Affordable Care Act and the Reconciliation Bill

**\*Note:**

The House/Senate Bill can be found at [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h3590eas.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf)

The Reconciliation Bill can be found at [http://docs.house.gov/rules/hr4872/111\\_hr4872\\_amndsub.pdf](http://docs.house.gov/rules/hr4872/111_hr4872_amndsub.pdf)

Provision	H.R. 3590 Patient Protection and Affordable Care Act (Passed by the Senate on 12/24/09 and the House on 3/21/10. Currently awaiting President Obama's signature.)	Amendment in the Nature of a Substitute to H.R. 4872, Health Care and Education Affordability Reconciliation Act (Passed in House on 3/21/10, currently pending in the Senate)
<b>Lifetime and Annual Limits</b>	<ul style="list-style-type: none"> <li>• <b>Lifetime Limits.</b> Prohibits lifetime dollar limits.</li> <li>• <b>Annual Limits.</b> For plan years before 2014, annual dollar limits on "essential health benefits" can only be imposed as determined by HHS (ensuring access to needed services with a minimal impact on premiums). For plan years starting in 2014, prohibits annual dollar limits.</li> </ul> <p>"Per beneficiary" annual or lifetime limits are permissible for items and services that are not essential health benefits. Lifetime and annual limits rules are effective for plan years starting 6 months after enactment. Applies to all markets. (§ 10101, PHSA § 2711, pp. 2034-36).</p>	<ul style="list-style-type: none"> <li>• Applies lifetime dollar limits provision to all existing plans effective for plan years beginning 6 months after enactment. (§ 2301(a), p. 149)</li> <li>• Applies annual limits provisions to existing group health plans (with the same effective dates as noted in the general provision). (§2301(a), pp. 149-150)</li> </ul>
<b>Rescissions</b>	<p>Coverage can only be rescinded for fraud or intentional misrepresentation of material fact and with prior notice to the enrollee. Applies to all markets.</p> <p>Effective for plan years starting 6 months after enactment. (§1001, PHSA § 2712, pp. 19-20)</p>	<p>Applies provision to all existing plans effective for plan years beginning 6 months after enactment. (§2301(a), p.149)</p>
<b>Preventive Health Services</b>	<p>Coverage of preventive health services (per specific recommendations by USPSTF, CDC, and HRSA). No cost-sharing. Applies to all markets. Effective for plan years starting 6 months after enactment. (§1001, PHSA § 2713, pp. 17-18)</p>	<p>No Changes</p>

**DISCLAIMER:** The information provided in this document is not intended to advise your business on how it may comply with any provisions of the referenced legislation, related legislation or regulations, nor is it otherwise intended to impart any legal advice. If you have any questions about how to comply with this or any other law or regulation, we recommend that you consult with your company's legal department or counsel. 1

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<b>Dependent Coverage</b>	<p>Group and individual coverage that provides dependent coverage must continue to make available coverage until a dependent turns 26.</p> <p>Applies to all markets. Effective for plan years starting 6 months after enactment. (§ 1001, PHSA § 2714, pp. 22-23)</p>	<ul style="list-style-type: none"> <li>• Applies provision to all existing plans effective for plan years beginning 6 months after enactment. (§2301(a), p.149)</li> <li>• For plan years beginning before 2014, applies to existing group health plans only if a dependent is not eligible to enroll in another employer-sponsored plan. (§2301(a), p.150)</li> <li>• Revises language to clarify covered dependents may be married or unmarried. (§ 2301(b), p.150)</li> </ul>
<b>Consumer Information</b>	<ul style="list-style-type: none"> <li>• <b>Notice of Mid-Year Changes.</b> Requires at least 60 days notice in advance of any material modification in coverage not reflected in most recent summary. Applies to all markets. Effective for plan years starting 6 months after enactment. (§ 1001, PHSA § 2715(d)(4), pp. 27-28)</li> <li>• <b>Uniform Coverage Summaries.</b> Requires plans to provide benefit summaries in a uniform format using standardized terminology at time of application, enrollment, and at policy delivery. Can be electronic. Penalties for willfully not providing. Applies to all markets (including existing plans). Effective 24 months after enactment. (§ 1001, PHSA § 2715, pp. 23-29, and § 10103(d)(2), p. 2065)</li> <li>• <b>Quality Requirements.</b> Requires plans to comply with annual reporting requirements on benefits and reimbursement structures established by HHS within 2 years of enactment. Includes reporting on how plans address health outcome improvement, preventable hospital readmissions, patient safety, and wellness and prevention programs. Applies to all markets. Effective 24 months after enactment. (§ 1001, PHSA § 2717, pp. 30-34)</li> </ul>	No Changes

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<b>Patient Protections</b>	<ul style="list-style-type: none"> <li>• <b>Patient Protections</b> <ul style="list-style-type: none"> <li>- Choice of participating primary care providers, including choice of pediatrician for children (for plans that require designation of a PCP). Effective for plan years starting 6 months after enactment.</li> <li>- Access to emergency care requirements (no prior authorization, equivalent cost-sharing for non-network and network providers, and a "prudent layperson" definition of emergency medical condition). Effective for plan years starting 6 months after enactment.</li> <li>- Direct access to OB/GYNs. Effective for plan years starting 6 months after enactment.</li> <li>- Provisions apply to all markets. Effective for plan years starting 6 months after enactment. (§10101(h), PHSA §2719A, pp. 2048-2054,).</li> </ul> </li> <li>• <b>Appeals.</b> Requires plans to establish a process for appeals of coverage determinations and claims in all markets. Internal appeals for group plans must follow the ERISA rules, as updated by DOL; individual plans must follow current legal requirements, as updated by HHS. External appeals for insured plans must follow state rules that, at a minimum, include consumer protections provided in the NAIC model act and make decisions binding on plans. HHS will set minimum rules for self-funded plans and insured plans (in states with inadequate rules) based on the NAIC model. Effective for plan years starting 6 months after enactment. (§ 10101(g), PHSA § 2719, pp. 2045-2048)</li> </ul>	No Changes
<b>Non-Discrimination Based on Salary</b>	Requires insured group health plans to meet current IRC § 105(h) (2) requirements for self-funded group health plans that prohibit discrimination in favor of highly compensated individuals. Effective for plan years starting 6 months after enactment. (§ 10101(d), PHSA § 2716, p. 2037)	No Changes

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<b>Reinsurance for Early Retirees</b>	Provides \$5B in federal reinsurance grants for early retiree employer coverage; includes plans <b>ES</b> sponsored by state and local governments. Effective 90 days after enactment. (§ 1102, pp. 52-58 and § 10102(a), pp. 2056-2057).	No Changes
<b>Children's Pre-existing Exclusions</b>	No pre-existing condition exclusions for individuals under age 19. Applies to all markets. Effective for plan years starting 6 months after enactment. (§ 10103(e), p. 2065)	No Changes

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