



BlueCross BlueShield of South Carolina
BlueChoice HealthPlan of South Carolina

Health Care Reform — Bulletin #4

May 21, 2010 (REVISED May 28, 2010)

Overview of Near Term Changes

This is part of a series of updates from BlueCross BlueShield of South Carolina and BlueChoice HealthPlan. The first update, on April 26, 2010, provided a general overview for employers. This update addresses key immediate, or near term, concerns for health benefit plans and individual members as a result of changes mandated by the Health Care Reform Law (i.e., the Patient Protection and Affordable Care Act of 2010 and Health Care and Education Reconciliation Act of 2010). Future updates will address mandates that take effect in later years.

These near term provisions generally take effect as of the first day of the next plan year beginning on or after September 23, 2010; for example, January 1, 2011, for calendar year plans. For individual policies, changes will take effect when the member's deductible year (benefit period) starts over for the first time after September 23, 2010.

Details continue to be defined

The Health Care Reform Law, with more than 2,000 pages, is about the length of three Harry Potter novels and contains new benefits, rules, penalties and projects spread out over several years. Regulations — which are still to come — may change how the law is interpreted. Our goal is to provide you with an understanding of the issues based on the information available today.

Key term: What is a grandfathered plan? A grandfathered plan is any group health plan or individual policy in effect as of March 23, 2010, the date the Health Care Reform law was passed. These plans keep the grandfathered status so long as no major changes or modifications are made; however, we do not currently know what changes can be made without losing this status.

Changes required in 2010

The Health Care Reform Law was enacted March 23, 2010. The benefit changes outlined on the next three pages are effective six months after enactment (September 23, 2010), but will take effect when the plan or policy renews the first time after September 23, 2010.

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<p>Expansion of Coverage for Young Adults</p>	<p>The law requires a plan that provides dependent coverage for children to continue to make that coverage available to an adult child (whether or not married) until the child turns 26. The plan is not required to make coverage available for a child or spouse of a child receiving dependent coverage.</p> <p>This mandate applies to grandfathered plans and non-grandfathered plans. However, until January 1, 2014, a grandfathered plan can limit this “to age 26 coverage” to children who are not eligible to enroll in other employer-provided coverage.</p> <p>Please note: The law does not mandate dependent coverage. Plans that do not offer dependent coverage are not required to offer it now.</p> <p>In advance of this mandate, BlueCross BlueShield of South Carolina and BlueChoice HealthPlan have decided to extend coverage up to age 26 for dependents currently enrolled in fully insured plans effective June 1, 2010.</p> <p>The law also amends the Internal Revenue Code to allow employers to continue to claim the federal tax exclusion for medical care benefits under an employer-provided plan so that benefits provided to an employee’s child who has not turned 27 as of the end of the year are excludible, even if the child does not otherwise meet the Code’s definition of dependent. For more information, please consult with your tax professional.</p>
<p>Lifetime and Annual Dollar Limits on Essential Benefits</p>	<p>A plan may not establish lifetime limits on the dollar value of “essential health benefits” for any enrollee. Also, a plan’s annual limits on the dollar value of essential health benefits will be restricted to “reasonable” limits (in accordance with regulations yet to be issued). The law prohibits these annual limits altogether after 2013.</p> <p>The lifetime dollar limit applies to grandfathered and non-grandfathered group and individual plans. The annual dollar limit for essential benefits applies to grandfathered and non-grandfathered group plans, but only to non-grandfathered individual plans.</p> <p>Regulations — yet to be published — will define “essential health benefits.”</p>
<p>Preventive Care Benefits</p>	<p>A plan must cover preventive services without any cost-sharing (e.g., deductibles, copayments and coinsurance). This includes A & B preventive services as identified by the United States Preventive Services Task Force; immunization recommendations from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and comprehensive guidelines supported by the Health Resources and Services Administration. To learn more about these services, visit these Web sites: http://www.ahrq.gov/clinic/pocketgd.htm http://www.ahrq.gov/clinic/pocketgd09/gcp09s1.htm http://www.cdc.gov/vaccines/pubs/acip-list.htm</p> <p>This mandate does not apply to grandfathered plans at this time.</p>

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<p>Emergency Services</p>	<p>A plan that provides benefits to stabilize and/or treat an emergency medical condition in the emergency department of a hospital cannot require preauthorization and different cost-sharing amounts if the emergency service provider is out of network.</p> <p>An Emergency Medical Condition is when a person has acute, severe symptoms, including severe pain; and when a prudent layperson with an average knowledge of health and medicine reasonably thinks that not seeking medical care: (1) would place the health of that person (or unborn child of a pregnant woman) in serious jeopardy; or (2) cause serious harm to bodily functions; or (3) cause serious dysfunction of any bodily organ or part.</p> <p>This would also apply to a pregnant woman who is having contractions when there is not enough time to safely get to another hospital before delivery, or if going to another hospital poses a threat to the health or safety of the woman or the unborn child.</p> <p>This mandate does not apply to grandfathered plans at this time.</p>
<p>Access to Pediatricians</p>	<p>A plan must allow a pediatrician to be designated as a child’s primary care physician so long as the provider participates in the plan’s network.</p> <p>This mandate does not apply to grandfathered plans at this time.</p> <p>BlueCross and BlueChoice HealthPlan already allow pediatricians to be designated as primary care physicians.</p>
<p>Access to Obstetrical and Gynecological Care</p>	<p>If a plan covers obstetric and gynecologic (OB/GYN) care, the plan cannot require female members to obtain an authorization or referral before seeing a participating provider who specializes in obstetrics or gynecology.</p> <p>This mandate does not apply to grandfathered plans at this time.</p> <p>BlueCross and BlueChoice HealthPlan already generally allow female members direct access to their obstetricians and gynecologists for routine services without a referral or prior authorization.</p>
<p>No Pre-existing Condition Exclusions for Children Under Age 19</p>	<p>A plan may not impose any pre-existing condition exclusion on members who are under 19 years of age, even if the child has a gap in coverage. (The law prohibits imposing pre-existing condition exclusions altogether after 2013.)</p> <p>This prohibition applies to grandfathered group plans and non-grandfathered individual and group plans. It does not apply to grandfathered individual plans.</p>

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<p>No Rescission</p>	<p>A plan may not cancel coverage <u>retroactively</u> (rescind coverage) for a member unless the member has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the individual policy.</p> <p>This has been the requirement in South Carolina for a number of years, and BlueCross and BlueChoice HealthPlan already follow this practice.</p> <p>This prohibition applies to grandfathered plans and non-grandfathered plans.</p> <p>Please note: coverage may still be cancelled for non-payment of premiums and other reasons defined in the plan or policy document.</p>
<p>Prohibition on Discrimination in Favor of Highly Compensated Individuals</p>	<p>An <i>insured</i> group health plan may not establish any eligibility rules that favor certain highly compensated employees. (Under prior law, only self-insured plans were subject to this nondiscrimination requirement.)</p> <p>The Internal Revenue Code defines “highly compensated employees.”</p> <p>This prohibition does not apply to a grandfathered plan until 2014.</p>
<p>Appeals Process</p>	<p>All plans must have written internal and external appeals procedures, and must advise members of those procedures in plan documents or their policy, or at certain other times as described by Department of Labor guidance.</p> <p>These mandates will apply to all new group and individual plans, but do not apply to grandfathered plans at this time.</p>
<p>Prohibition of Discrimination Based on Lawful Ownership or Possession of Firearms or Ammunition</p>	<p>Plan may not base eligibility, premiums, discounts, rebates or rewards on the lawful use, ownership, or possession of firearms or ammunition, nor may a plan request this information as part of a wellness program or for any use related to the Health Care Reform Act.</p> <p>These prohibitions do not apply to a grandfathered plan.</p>

Helpful Web Sites

Visit these sites to learn more about health care reform:

Department of Labor: www.dol.gov/ebsa/healthreform/

Department of Health and Human Services: www.healthreform.gov

The White House: www.whitehouse.gov/healthreform

This bulletin is part of a series of bulletins we are publishing as we gather information about the health care reform law enacted March 23, 2010. To access all of the bulletins released so far, please visit our Web sites (SouthCarolinaBlues.com or BlueChoiceSC.com). Click on the appropriate tab (Members, Agents, Benefits Coordinators/Group Administrators or Providers); then click on the “Health Care Reform” link to view the list of the bulletins.

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