

## **The Patient Protection and Affordable Care Act Frequently Asked Questions**

The following are answers to questions submitted in relation to policy form filings and the Patient Protection and Affordable Care Act (PPACA) changes that take effect for plan or policy years beginning on or after September 23, 2010 (“six month PPACA changes”). Additional questions may be submitted to [health@ins.state.ny.us](mailto:health@ins.state.ny.us).

### **ANNUAL AND LIFETIME MAXIMUMS**

#### **1. Are the PPACA annual and lifetime maximums applicable to both in-network and out-of-network coverage?**

Yes. Federal rule 45 CFR § 147.126 sets forth the permissible annual and lifetime maximums. The federal rule does not distinguish between in-network and out-of-network coverage. The annual and lifetime maximums are therefore applicable to both in-network and out-of-network coverage.

#### **1. Are the PPACA annual and lifetime maximums applicable to conversion policies?**

Yes, the PPACA annual and lifetime maximums apply to conversion policies.

### **DEPENDENT COVERAGE TO AGE 26**

#### **1. Are benefit variations for dependent children based on age permissible? For example, some products provide for no cost sharing for children under 19. Similarly, coverage for certain benefits such as eyeglasses and hearing aids is often more expansive for children under age 19.**

Federal rule 26 CFR 147.120(d) states “terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age.” In various examples, the regulation indicates that the benefit package may not vary based on age and that health plans may not impose surcharges based on age. Adult children to age 26 must be offered the same benefits and under the same terms as younger children. Therefore, it does not appear that benefit variations based on age are permitted.

#### **2. Can groups refuse to purchase dependent coverage to age 26 prior to the effective date of the law or prior to their renewal date?**

Yes. There is nothing in federal or state law that would require groups to implement this provision prior to the effective date of the law or prior to their renewal date.

### **EMERGENCY SERVICES**

#### **1. Are New York requirements that HMOs hold enrollees harmless for emergency services still applicable?**

Yes, New York hold harmless requirements are applicable.

## **GRANDFATHERING**

### **1. Will the Department permit a health plan to have a single product with different benefits depending on whether the group covered by the product is grandfathered or non-grandfathered?**

Yes. The Department will permit a health plan to have a single product for both grandfathered and non-grandfathered groups wherein the appropriate PPACA compliant rider will be issued to add the benefits required by PPACA to the base policy.

Note that due to open enrollment requirements, health plans must offer the fully PPACA compliant rider to any grandfathered group in the small group market that wants to purchase it. See 11 NYCRR 360 (Regulation 145).

## **PRE-EXISTING CONDITIONS**

### **1. Can health plans impose a pre-existing condition waiting period instead of an exclusion?**

Beginning September 23, 2010, upon issuance or renewal of coverage, plans may not impose a pre-existing condition exclusion or waiting period on persons under age 19. Section 2704(a) of the Public Health Service Act, as amended by PPACA, states that a plan “may not impose any pre-existing condition exclusion.” Section 2704(b) and Federal rule 45 CFR § 144.103 define a pre-existing condition exclusion as “a limitation or exclusion of benefits.” As a pre-existing condition waiting period would be a limitation, such waiting period would not be permitted. For persons age 19 and older the prohibition against the imposition of a pre-existing condition exclusion or waiting period is effective upon issuance or renewal on or after January 1, 2014.

## **PREVENTIVE SERVICES**

### **1. Can health plans still apply cost sharing if the purpose of a visit is diagnostic, even though some preventive services are provided during the visit (e.g. blood pressure screening)?**

Yes, in this example health plans can still apply cost sharing. See Federal rule 45 CFR §147.130.

### **2. Can the PPACA benefit for preventive services be described in the contract by referencing the appropriate sources (e.g. Preventive services will be covered in accordance with the USPSTF recommendations for services that have an A or B rating)?**

Such a description will be permitted if the health plan includes a statement in the contract that the list of covered services is available on the health plan’s web site and will also be sent to a subscriber upon request.

## **HEALTHY NEW YORK**

### **1. Are the Healthy New York limits on prescription drugs impacted by PPACA?**

Yes. As of September 23, 2010 all **new group and individual** Healthy New York plans, and upon renewal on and after September 23, 2010 all **grandfathered group** Healthy New York plans will be subject to PPACA and will not be permitted to include the \$3,000 annual limit for prescription drugs. Pursuant to Section 2711(a)(1)(B) and (2) of the Public Health Service Act as amended by PPACA and Federal rule 45 CFR §147.126, annual limits on the dollar value of essential benefits are prohibited, except that plans will be allowed to set restricted annual limits on essential benefits until January 1, 2014. Section 1302(b)(1)(F) of PPACA lists prescription drugs as an essential benefit. Annual limits must meet or exceed the minimums established in the federal regulation as follows:

For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011 - \$750,000;

For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012 - \$1.25 million; and

For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014 - \$2 million.

For plan or policy years beginning on or after January 1, 2014 – annual limits are not permitted.

**2. Are grandfathered individual Healthy New York plans subject to the requirements for prescription drug coverage described above?**

No. For grandfathered individual Healthy New York plans, the \$3,000 annual limit for prescription drugs remains. The provision relating to annual limits in grandfathered plans (Section 1251(a)(4)(B)(i) of PPACA) applies only to grandfathered group plans, not grandfathered individual plans.

**3. Can the Healthy New York \$3,000 annual prescription drug maximum be applied to retail drugs for both grandfathered and non-grandfathered plans if the mail order program is unlimited or capped at \$750,000?**

No. There is nothing in the federal law or regulations that allows such a distinction. The appropriate PPACA limits shall be applied to all prescription drug benefits.

**4. Can current Healthy New York groups/subscribers be moved at the option of the carrier into the non-grandfathered, fully PPACA compliant Healthy New York plan?**

No. Current groups/subscribers enrolled on or before March 23, 2010 should be maintained in the grandfathered plans unless they choose to move to a non-grandfathered plan. Subscribers who enrolled after March 23, 2010 but before September 23, 2010 are not grandfathered and must be issued the non-grandfathered, fully PPACA compliant Healthy New York plans upon renewal. Subscribers who enroll on or after September 23, 2010 must be issued fully PPACA compliant Healthy New York plans.

**5. Healthy New York rules provide members with the option to change their benefit package at the time of annual recertification or when there is a change in premium per 11 NYCRR 362-2.7. Must new groups / subscribers enroll in the non-grandfathered, fully PPACA compliant Healthy New York plan?**

Yes. Pursuant to Section 1251 of PPACA, only plans in effect on March 23, 2010 are grandfathered. Beginning September 23, 2010, new subscribers must be issued fully PPACA compliant coverage.

**6. Are there any specific benefit changes that will be made to the Healthy New York plans?**

The benefit changes that must be made to the Healthy New York plans to ensure compliance with PPACA are contained in the model PPACA riders posted on the Insurance Department's web site at <http://www.ins.state.ny.us/ihealth.htm>. We do not anticipate any other state mandated changes at this time.

**7. Is the model PPACA rider language on the Insurance Department's web site acceptable for use in connection with Healthy New York?**

Yes, the model rider language posted on the Insurance Department's web site (<http://www.ins.state.ny.us/ihealth.htm>) is acceptable for use with Healthy New York.

**INDIVIDUAL STANDARDIZED DIRECT PAYMENT HMO AND POS COVERAGE**

**1. Is the annual limit for private duty nursing removed completely or replaced with the new permissible maximum?**

Such limit would be impermissible under PPACA only if private duty nursing is considered an essential health benefit under the federal law. We are still awaiting federal guidance regarding what is considered an essential health benefit. In the absence of federal guidance, HMOs should continue to impose the \$5,000 annual limit for private duty nursing in the standardized direct payment contracts.

**2. Can current individual direct payment subscribers initially be moved into the non-grandfathered, fully PPACA compliant direct payment plans with the option of choosing the grandfathered plans if that is their preference?**

No. Current subscribers who were enrolled on or before March 23, 2010 must be maintained in the grandfathered plans unless they choose to move to a non-grandfathered plan. Subscribers who enrolled after March 23, 2010 but before September 23, 2010 must be issued the non-grandfathered, fully PPACA compliant direct pay plans upon renewal. Subscribers who enroll on or after September 23, 2010 must be issued fully PPACA compliant direct payment plans.

**3. Are there any specific benefit changes that will be made to the individual standardized direct payment plans?**

The benefit changes that must be made to the individual standardized direct payment plans to ensure compliance with PPACA are contained in the model PPACA riders

posted on the Insurance Department's web site at <http://www.ins.state.ny.us/ihealth.htm>. We do not anticipate any other state mandated changes at this time.

**4. Is the model PPACA rider language on the Insurance Department's web site acceptable for use in connection with the individual standardized direct payment policies?**

Yes, the model rider language posted on the Insurance Department's web site (<http://www.ins.state.ny.us/ihealth.htm>) is acceptable for use with the individual standardized direct payment policies.

**LIMITED BENEFITS COVERAGE**

**1. Are the "six month PPACA changes" applicable to limited benefits coverage?**

For basic hospital, basic medical and expense incurred limited benefits coverage (including hospital indemnity coverage with dollar amounts in excess of the dollar amounts in 11 NYCRR 52.5 or 52.6) the "six month PPACA changes" are applicable.

For limited benefit policies that provide fixed indemnity benefits or hospital indemnity coverage equal to or less than 11 NYCRR 52.5 or 52.6, the "six month PPACA changes" do not apply because hospital indemnity and other fixed indemnity insurance are not subject to the provisions of PPACA pursuant to Section 2791(c)(3)(B) of the Public Health Service Act.

**IMPLEMENTATION**

**1. Can a health plan apply all "six month PPACA changes" to all groups as of a date certain that may be prior to a group's renewal date?**

Yes, other than for Healthy New York, as long as it is not mandatory and the group is given the option to keep its existing coverage until renewal and as long as there is no immediate or retroactive impact on premiums.

**2. If the "six month PPACA changes" are applied on a group's renewal date would this be considered a class discontinuance or a unilateral modification?**

It would be considered a unilateral modification and would be subject to § 52.18(a)(8) of Insurance Regulation 62 (11 NYCRR 52).