

CHANGES DUE TO FEDERAL HEALTH CARE REFORM

On March 23, 2010, President Obama signed into law the health care reform bill, the Patient Protection and Affordable Care Act (PPACA). This legislation, along with the Health Care and Education Reconciliation Act of 2010 (Both acts collectively known as federal Health Care Reform (HCR), made sweeping changes to the U.S. health care system that will be implemented over the next several years.

Beginning January 1, 2012, the State Health Benefits Program /School Employees' Health Benefits Program (SHBP/SEHBP) will lose its grandfathered status. As a result, there are a few changes required by HCR to all plans administered by the Programs.

Preventive Services

Under HCR, certain preventive care, such as immunizations (age and population restrictions may apply), certain screenings (blood pressure, cholesterol, depression, newborn, etc.), FDA-approved contraceptive methods, and well-baby care, must be covered without member cost-sharing. Therefore, primary care well visits (annual exams) will no longer require a copayment or coinsurance by the member. Note: This applies only when these services are delivered by a network provider. Also, if the preventive service is not the primary reason for the office visit, the member may still be responsible for a copayment or coinsurance. Contact your medical plan for more information.

Children up to Age 26

A child up to age 26 is eligible for coverage under the parent's coverage even if the child is eligible for other employer-based coverage. Previously, the SHBP/SEHBP denied coverage if the child was eligible for other employer-based coverage. A "child" is defined as an enrollee's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his parents. A *photocopy* of the child's birth certificate that includes the covered parent's name must be submitted along with the application (and additional supporting documentation for foster or stepchildren).

New Appeals Process Required

The appeal process for medical and prescription drug claims will change effective January 1, 2012. After the internal appeal process with the medical or prescription drug carrier, members will be eligible to have their appeals heard by an independent review organization (IRO). Normally, the decision of the IRO is binding on the plan. The types of claims that can be appealed generally include denials, reductions in benefits, or termination of coverage. More detailed information will be provided by the beginning of 2012 in the *Member Handbooks* and *Summary Program Description (SPD)*.