

Health Insurance Reforms

A step-by-step walkthrough to find out:

A) What type of insurance plan you have, and

B) Which health reform provisions apply to it

Definitions of Important Terms

Individual Insurance Market:

The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.

Group Health Plan:

Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

Self-Insured Plan:

A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. A type of group plan.

Grandfathered and Non-grandfathered Health Plans:

A "grandfathered" or "non-grandfathered" plan refers to a health plan's status in regard to Health Reform. Health plans that covered individuals and families on the day that the health reform law was enacted, March 23, 2010, may be considered grandfathered plans.

Health Insurance Reform: What You Need To Know

More Information on Grandfathered and Non-Grandfathered Plans

The baseline for plans that are considered grandfathered is their benefit package, including cost-sharing, as of March 23, 2010, the date the health reform bill was signed into law. Be aware that at any point, a grandfathered plan may become a non-grandfathered plan if significant changes occur, such as increased cost-sharing or reduced benefits.

The law requires your insurance company to tell you whether your plan is grandfathered or not

Any individual plan that you enroll in after this date is automatically **not** a grandfathered plan.

Any one of the following changes will automatically make a grandfathered health plan a new (non-grandfathered) plan, whether you buy it on your own or get it through an employer:

- Increase in coinsurance (your percentage share of your health care bills) by any amount.
- Increase in copayments, deductibles, or out-of-pocket limits by more than medical inflation plus 15 percentage points. In recent years, medical inflation has been between 4 and 5 percent a year, therefore an increase of 19 to 20 percent in any of these categories would trigger the change - for instance, if your deductible were to go from \$1,000 to \$1,250 a year.
- Elimination or significant reduction in benefits to diagnose or treat a particular condition.
- Switching to a new insurance carrier. (This does not apply to large self-insured companies that pay employee health expenses out of their own pockets instead of buying coverage from an insurance company. *If you are not sure what kind of employer health insurance you're offered, check with your benefits manager.*)

One trigger that changes a grandfathered plan to a non-grandfathered plan applies to employer group plans only:

- Increase of more than 5 percentage points of the share of premiums that the employee has to pay. For instance, if you are paying 30 percent of your plan's cost this year, and next year it's 40 percent, the plan will no longer be grandfathered.

For more information, please contact:

Champaign County Health Care Consumers

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Health Alliance

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Health Care Reform and Your Health Alliance Plan

It's a priority for us to keep you informed about changes to your benefit plan—especially those tied to health care reform—so you can communicate with your employees accordingly. Rest assured that Health Alliance is actively engaged in both short and long term planning to provide you and your employees with high quality health care coverage. We will make adjustments as the rules are released and will keep you informed of the changes. Enclosed with your renewal are a Health Care Reform Implementation Timeline and Quick Reference flier that outline the overall timeline of the legislation. Look for invitations to upcoming webinars that will provide additional education on how Health Care Reform will affect your employer group coverage.

Please provide your email address to your account representative to be included in email updates and webinars.

What is a Grandfathered Plan?

A “grandfathered” or “non-grandfathered” plan refers to a group health plan’s status in regards to Health Care Reform. Being a grandfathered health plan means that your plan is not required to include certain provisions of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other provisions in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

After in-depth analysis of the benefits and implications of grandfathering plans, a few overarching factors continue to rise to the top.

- Grandfathering does not eliminate all the requirements of the health care reform legislation (e.g. lifetime dollar limits).
- Maintaining grandfathered status puts strict limits on member cost-sharing increases, and it increases the employer’s and the health plan’s administrative burden.
- We have seen many projections, including those from HHS, which estimate most plans will lose grandfathered status over time.

We have, therefore, made the following business decisions regarding grandfathering.

- All Health Alliance groups subject to Small Employer Health Insurance Rating Act requirements will not be grandfathered.

Your benefit plan is considered “non-grandfathered” in regard to Health Care Reform.

Changes to Your Benefit Plan

The good news is that not many changes are needed, because Health Alliance is already meeting the majority of the health care reform requirements, including providing first-dollar preventive care services.

■ PersonalCare announces ■

NEW OR EXPANDED HEALTH CARE REFORM BENEFITS



Beginning with plans **effective October 1, 2010**, PersonalCare will exclusively offer benefit plans **that meet all health care reform requirements in the 2 – 99 employee market.**

HIGHLIGHTS OF NEW OR EXPANDED BENEFITS INCLUDED IN OUR BENEFIT PLANS

- Young adult dependents can enroll up to age 26. Benefit plans will cover dependents age 26 and older if required by state law.
- Newborns and children up to and including age 18 will receive coverage for the services and medication needed to treat pre-existing conditions.¹
- No lifetime or annual maximum dollar limits for in-network services.
- Member copayment and/or coinsurance for emergency services will be the same regardless if you receive the services from an in or out-of-network provider.
- Preventive care received from network providers will be paid at 100 percent. Preventive care includes but is not limited to:
 - › Blood pressure screenings
 - › Diabetes screenings
 - › Tobacco counseling for adults
 - › Select immunizations for children ages 0-6 years
 - › Flu shots for adults
 - › Counseling for diet

Please contact your PersonalCare representative to learn more about the new and expanded benefits.

■ Preventive Care Coverage ■

PREVENTIVE CARE SERVICES ARE KEY FOR MEMBERS

At Coventry Health Care, we encourage members to receive preventive care services. The Patient Protection and Affordable Care Act (PPACA) provides for specific preventive services when provided by participating providers to be covered at 100 percent. Our fully insured group health plans already provide coverage for many of those preventive services. Starting on October 1, 2010, for all new plans and for renewing plans that are not grandfathered plans, as of the plan's effective date/renewal date, members who use our network providers will receive preventive care services paid at 100 percent.

COVERAGE FOR PREVENTIVE SERVICES

Here are some examples of the preventive services that will be covered with no copay, coinsurance or deductible.

Child Preventive	Adult Preventive
Exams: Preventive office visits including well child care	Exams: Preventive office visits including well woman exam
Immunizations: Influenza (flu) Pneumonia Hepatitis A Hepatitis B Diphtheria, Tetanus, Pertussis Varicella (chicken pox) Measles, Mumps, Rubella (MMR) Polio Rotavirus Meningococcal Human Papillomavirus (HPV)	Immunizations: Influenza (flu) Pneumonia Hepatitis A Hepatitis B Diphtheria, Tetanus, Pertussis Varicella (chicken pox) Measles, Mumps, Rubella (MMR) Polio Rotavirus Meningococcal
Screening Tests: Hearing screening, Eye chart screening, PKU screening (newborns), Sickle cell screening (newborns)	Screening Tests: Breast cancer screening, Cervical cancer screening, Colorectal cancer screening, Prostate cancer screening, Bone density, Lipid panels, Abdominal aneurysm aortic screening, Screening for sexually transmitted diseases, HIV test, General and immunological labs, Routine blood and urine screenings
Newborn Preventive Treatment: Gonorrhea treatment	

The list is subject to change as federal guidance is issued. The full list of covered preventive services issued with the Interim Final Rules can be found at <http://www.healthcare.gov/center/regulations/prevention/taskforce.html>

Talking with Your Provider about Preventive Care

We process claims based on your provider's clinical assessment of the office visit. If a preventive item or service is billed separately, cost-sharing may apply to the office visit. If the primary reason for your visit is seeking treatment for an illness or condition, and preventive care is administered during the same visit, cost-sharing may apply. This means your provider may ask you to pay your appropriate health plan copay, deductible or coinsurance.

Certain screening services, such as a colonoscopy or mammogram, may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening,

any subsequent testing, diagnosis, analysis or treatment are not considered preventive services and are subject to the appropriate cost-sharing.

If you have questions about a claim or provider visit, please call the customer service number on your Member ID card or speak with your provider. Please regularly check our website for new information about preventive care coverage as the government agencies refine guidance and requirements.

Health Insurance Reform: What You Need To Know

Health Insurance Worksheet

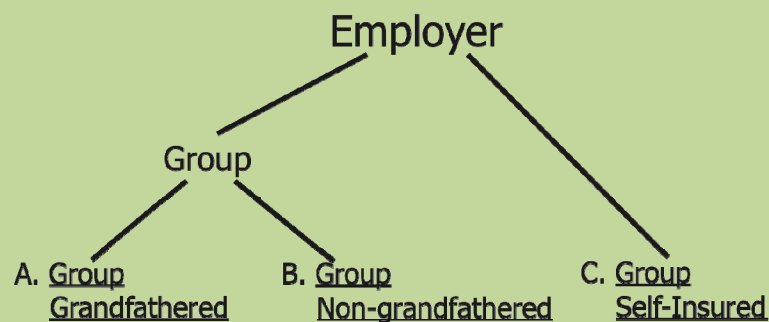
Please work through this worksheet to find out what insurance regulations apply to you.

Do you have insurance through your (or your spouse's) **EMPLOYER** or do you buy your insurance directly on the **INDIVIDUAL MARKET**? (Go to the corresponding column.)

Employer

Does your employer purchase a GROUP plan, or is your employer SELF-INSURED?

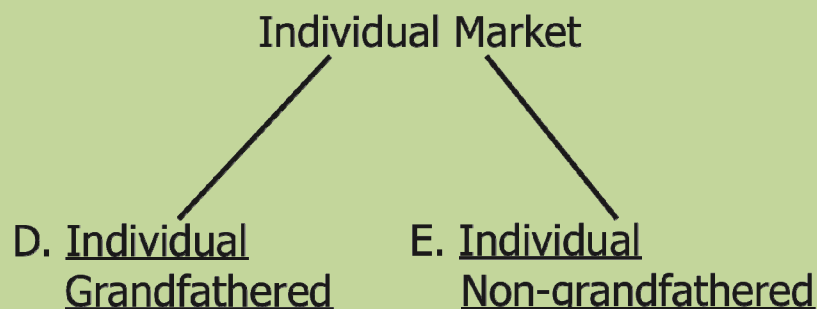
Is your employer plan a GRANDFATHERED plan or is it an NON-GRANDFATHERED plan?



Match your corresponding group letter at the bottom of this worksheet with the corresponding column on the Health Reform Provisions Chart handout.

Individual Market

Is your individual plan a GRANDFATHERED plan or is it an NON-GRANDFATHERED plan?



Match your corresponding group letter at the bottom of this worksheet with the corresponding column on the Health Reform Provisions Chart handout.

Health Insurance Reform: What You Need To Know

Health Reform Provisions Chart - Effective 9/23/10*

Provision	A.	B.	C.	D.	E.
	Group Grandfathered	Group Non-grandfathered	Group Self-Insured	Individual Grandfathered	Individual Non-grandfathered
Prohibition against unfair rescissions of coverage	YES	YES	YES	YES	YES
Children can stay on their parents' health plans until age 26	YES**	YES	YES	YES	YES
Prohibition of lifetime limits in coverage	YES	YES	YES	YES	YES
Annual limits in coverage to be phased out over the next three years	YES	YES	YES	NO	YES
Prohibiting the exclusion of children under the age of 19 from obtaining coverage based on pre-existing conditions	YES	YES	YES	NO	YES
Preventive services covered with no co-pays or deductibles	NO	YES	YES	NO	YES
Patient Protections: OB/GYN access without a referral; Pediatricians classified as primary care providers; Choice of primary care providers; No higher cost-sharing for out-of-network emergency services; No prior authorization requirements for emergency care.	NO	YES	YES	NO	YES
Right to internal and external appeals of insurer decisions.	NO	YES	YES	NO	YES
Subject to Medical Loss Ratio (MLR) requirements for fully insured plans: Insurers must spend a set share of premium dollars on medical care and quality improvements. (Effective on or after 1/1/11)	YES	YES	NO	YES	YES

* Effective for health plan years starting on or after September 23, 2010 (except the Medical Loss Ratio provision that goes into effect on or after 1/1/11). For example, some health plan years start in October, whereas others, such as the Federal Employees Health Benefits Program (FEHBP) plan year, do not start until January. After September 23, 2010, whenever an individual's health plan year starts again is when the provision will apply to him or her.

** Until 2014, this provision applies only if a young adult does not have another offer of job-based coverage (excluding offer from another parent's job-based plan).

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