Health Insurance Reform: What You Need To Know

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

	A.	B.	C.	D.	E.
Provision	**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).

For more information, please contact:

Champaign County Health Care Consumers

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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.

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