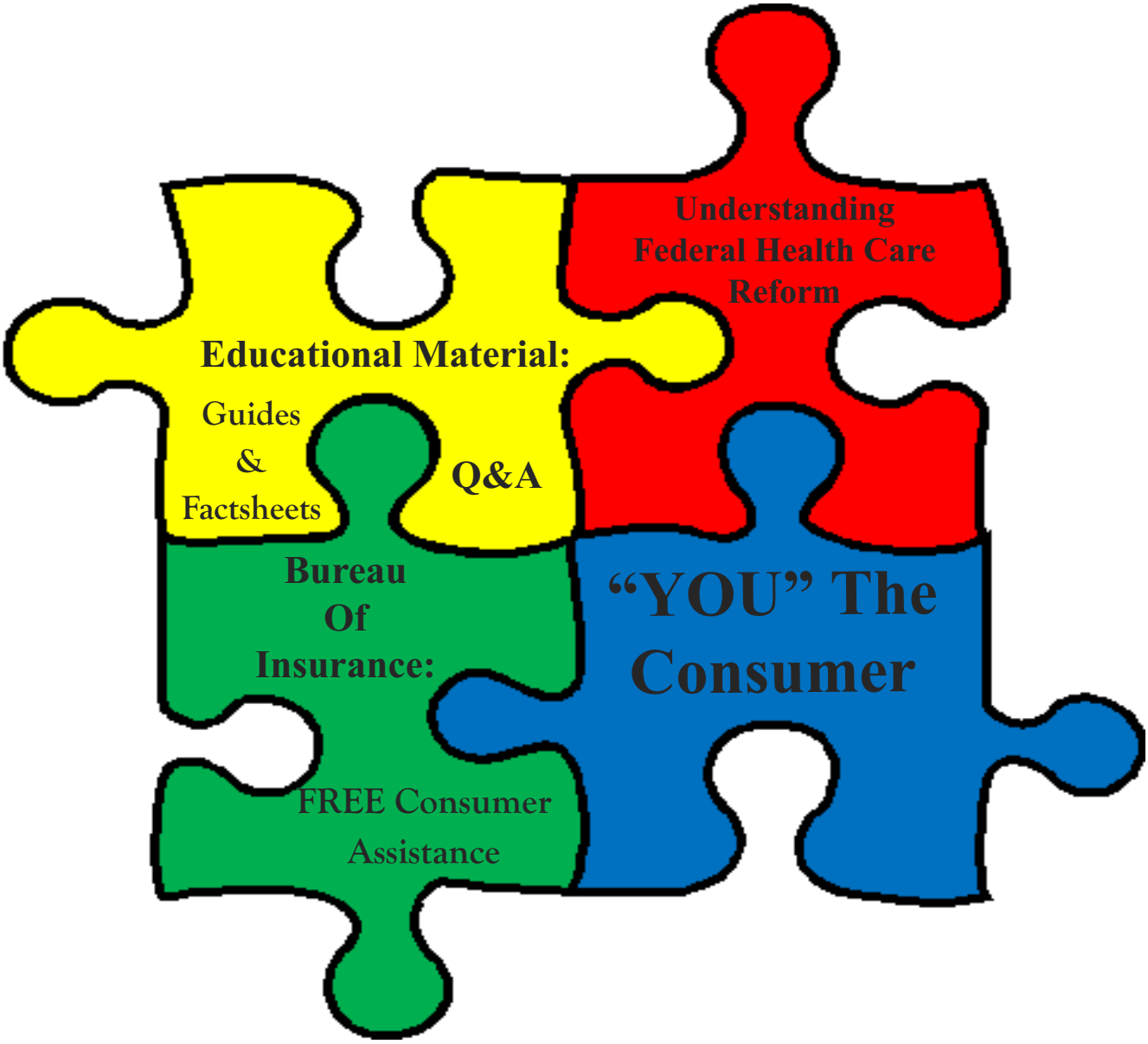
FEDERAL HEALTH CARE REFORM

Do Recent Changes In Federal Health Care Reform Have You Puzzled?



KNOWLEDGE IS YOUR BEST POLICY...

PREPARED BY THE
BUREAU OF INSURANCE
STATE CORPORATION COMMISSION
COMMONWEALTH OF VIRGINIA

Virginia
Consumer's Guide

Immediate Provisions Of Federal Health Care Reform

Frequently Asked Questions and Glossary of Terms

The information contained in this document should be used for educational purposes only. Nothing in this document is intended to be an opinion, legal or otherwise, of the State Corporation Commission, nor should it be construed as an endorsement of any product, service, person or organization mentioned in this document.

February 2012 Printing

Commonwealth of Virginia
State Corporation Commission
Bureau of Insurance
Post Office Box 1157
Richmond, Virginia 23218
Web Site - www.scc.virginia.gov/boi
Email Address - BureauofInsurance@scc.virginia.gov

Important Contact Information

For more information concerning your health benefit plan or policy, or if you want more information about anything explained in this document, you may contact:

Virginia State Corporation Commission
Bureau of Insurance
Mailing Address:
Post Office Box 1157
Richmond, VA 23218
Street Address:
1300 E. Main Street
Richmond, VA 23219
Toll-free: 1-877-310-6560
FAX: (804) 371-9944
TDD: (804) 371-9206
Website: www.scc.virginia.gov/boi
Email: Bureauofinsurance@scc.virginia.gov

For more information concerning federal health care reform, you may also visit: www.HealthCare.gov.

For more information specifically relating to employment- based group health benefit plans, you may also contact:

The United States Department of Labor
1-866-444-3272
or
www.dol.gov/ebsa/healthreform

Immediate Reforms in the Affordable Care Act and Corresponding Virginia Law

The Affordable Care Act became federal law on March 23, 2010, when it was signed by the President. Some provisions of this federal law took effect immediately, but most will be phased in over time. Several of the law's provisions relating to insurance reforms become effective as group health benefit plans and health insurance carriers issue new plans or policies or renew existing plans or policies on or after September 23, 2010 (6 months from the effective date of the legislation). For purposes of this document, these provisions are referred to as the "immediate reforms." In Virginia, state laws were revised during the 2011 session of the Virginia General Assembly to substantially conform Virginia laws to most of the coverage requirements identified as the "immediate reforms" in the ACA.

Some provisions of the federal law will apply to all health benefit plans and policies. Other provisions will not apply to health benefit plans and policies issued or renewed on or after September 23, 2010, if the plans or policies are grandfathered health benefit plans or policies. Grandfathered health benefit plans or policies are those that were in effect as of March 23, 2010. Certain changes to such an existing plan or policy, however, may cause it to lose its grandfathered status. If you are covered by a grandfathered health benefit plan or policy, you should receive a notice indicating such status with your coverage documents at the time your coverage renews. You are encouraged to contact the Bureau of Insurance with any questions you have about these new federal laws, and the implications the new laws may have on your situation.

Note: There are certain types of insurance which only provide coverage for certain health conditions and are not subject to the requirements of the new federal health care reform laws.

Contained herein is important information concerning the immediate reforms for health benefit plans and policies issued or re-issued on or after September 23, 2010. These FAQs discuss the immediate reforms which are:

(i) restrictions on annual dollar limits on essential benefits, except for grandfathered policies providing individual health insurance coverage; and elimination of lifetime dollar limits on essential benefits (refer to Dollar Limits on Your Benefits, page 1);

(ii) a prohibition on the rescission of health insurance policies except in cases of fraud or misrepresentation of a material fact (refer to Insurance Cancellations, page 3);

(iii) requirements that nongrandfathered health benefit plans or policies cover preventive services without out-of-pocket cost-sharing for the insured (refer to Cost for Preventive Services, page 5);

(iv) requirements that nongrandfathered health benefit plans or policies permit covered persons to designate any participating primary health care professional who is available to accept the covered person, and prohibitions of such plans requiring authorizations or referrals for obstetrical or gynecological care by in-network health care professionals specializing in obstetrics or gynecology (refer to Choice of Health Care Providers, page 8);

(v) prohibitions on nongrandfathered health benefit plans or policies imposing pre-existing condition exclusions for enrollees who are under 19 years of age, except a grandfathered policy providing individual health insurance coverage, (refer to Children with Pre-existing conditions, page 10);

(vi) requirements that health benefit plans or policies providing dependent coverage for a child provide such coverage until the child reaches age 26 (refer to Adding Adult Children to your Coverage, page 12); and

(vii) insurance companies are limited on how much of your premium dollar they can spend on administrative costs, marketing, and other non health care-related costs (refer to Your Premium Dollar, page 14).

Contents

Page 1	**Dollar Limits on Your Benefits**
Page 3	**Insurance Cancellations**
Page 5	**Cost for Preventive Services**
Page 8	**Choice of Health Care Providers**
Page 10	**Children With Pre-Existing Health Conditions**
Page 12	**Adding Adult Children to Your Coverage**
Page 14	**Your Premium Dollar**
Page 17	**Are You Covered By a Grandfathered Health Benefit Plan or Policy?**
Page 21	**Glossary of Terms**

Note: throughout this document, terms defined in the Glossary of Terms are *italicized*.

Dollar Limits on Your Benefits

The *Affordable Care Act (ACA)* and Virginia law prohibit insurers from imposing *lifetime dollar limits* and phases out *annual dollar limits* on *essential benefits*.

Q: How do the Affordable Care Act (ACA) and Virginia law change lifetime dollar and annual dollar limits on my benefits?

A: Before the enactment of the ACA and Virginia law, many insurers set an annual dollar limit on their spending for your covered benefits. Many insurers also set a lifetime dollar limit on what they would spend for your covered benefits during the entire time you were insured under that *health benefit plan* or *policy*. You were required to pay the cost of all care that exceeded those dollar limits. The ACA and Virginia law prohibit insurers from putting a lifetime dollar limit on most benefits you receive. The ACA and Virginia law also restrict and phase out annual dollar limits an insurer can place on most of your benefits. The ACA does away with these annual dollar limits entirely in 2014.

Q: Will these bans and restrictions on dollar limits apply to my health benefit plan or policy?

A: The ban on lifetime dollar limits applies to all *group health benefit plans*, and all *individual health insurance policies* purchased for you and your family.

The phase-out of annual dollar limits applies to all group health benefit plans and individual health insurance policies, except grandfathered* individual health insurance, and those health benefit plans or policies that received the waiver described on the next page.

Q: When will the new lifetime and annual dollar limits rules take effect?

A: If this part of the ACA and Virginia law applies to your health benefit plan or policy, the new rules will affect you as soon as you begin a new *plan year* or *policy year* on or after September 23, 2010.

*** Refer to explanation on Page 17.**

Q: How do the ACA and Virginia law phase out annual dollar limits?

A: The ACA and Virginia law phase out annual dollar limits for all health benefit plans or policies except those individual health insurance policies that are considered grandfathered,* by specifying that none of these health benefit plans or policies can set an annual dollar limit on most benefits lower than:

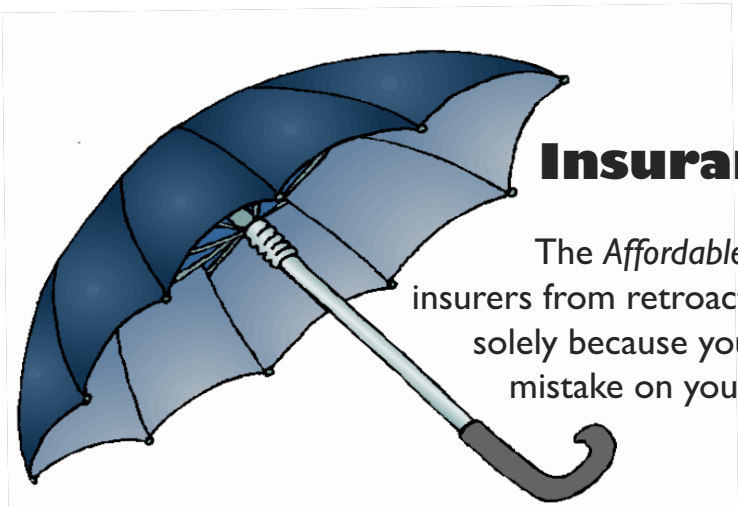
- **$750,000** — for a plan year or policy year starting on or after September 23, 2010, but before September 23, 2011.
- **$1.25 million** — for a plan year or policy year starting on or after September 23, 2011, but before September 23, 2012.
- **$2 million** — for a plan year or policy year starting on or after September 23, 2012, but before January 1, 2014.

No annual dollar limits are allowed on most covered benefits in a plan year or policy year that begins on or after January 1, 2014.

Some Important Details:

- Be aware that your health benefit plan or policy can put an annual dollar limit and a lifetime dollar limit on spending for health benefits that are not essential benefits as defined in the law. (Essential benefits include, but are not limited to, doctor office visits, hospitalizations, and prescriptions.)
- Some health benefit plans or policies may be eligible for a waiver from the rules concerning restricted annual dollar limits, if complying with the limit would mean a significant decrease in your benefits coverage or a significant increase in your *premiums*. Plans granted such waivers are listed at: http://cciio.cms.gov/resources/other/index.html#alw

*** Refer to explanation on Page 17.**



Insurance Cancellations

The *Affordable Care Act (ACA)* and Virginia Law stop insurers from retroactively cancelling your insurance coverage solely because you or your employer made an honest mistake on your insurance application.

Q: How do the Affordable Care Act (ACA) and Virginia law affect insurance cancellations?

A: Before the enactment of the ACA and Virginia law, if your insurer found that you made a mistake on your insurance application, the insurer might have been able to *rescind* your coverage. That means, your insurer would declare your *policy* invalid from the day it began. Your insurer might also ask you to pay back any money already spent for your medical care. Under the new ACA and Virginia law, an insurer cannot rescind your coverage simply because you made an honest mistake.

Q: How would this new insurance cancellation rule work?

A: Here's an example of how this would work:
When Katy's insurance application asked for "anything else relevant to your health that we should know" Katy forgot to mention two visits to a psychologist she had 6 years earlier. Katy was later diagnosed with breast cancer and submitted claims to her insurance company for breast cancer treatment. After receiving Katy's claim, her insurer discovered the two psychologist visits. Before the new law, Katy's mistake might have prompted her health insurer to rescind or retroactively cancel her coverage. Under the new law, Katy's insurer cannot rescind her coverage because Katy did not intentionally misrepresent significant information.

Q: Does this insurance cancellation rule apply to my *health benefit plan* or policy?

A: This provision applies to all *group health benefit plans* and *individual health insurance policies* purchased for you and your family.

Please note:

- Your insurer can still rescind your coverage if you intentionally put false or incomplete information on your insurance application.
- Your insurer can still cancel your coverage if you fail to pay your *premiums* on time.

Q: When does this insurance cancellation rule take effect?

A: This rule applies to *plan years* or *policy years* that begin on or after September 23, 2010.

Q: How will I know if my insurer is going to rescind my coverage?

A: If your insurer determines that you intentionally put false or incomplete information on your insurance application, they must give you at least 30 days' notice before they can rescind your coverage; during that time, you may appeal the decision or find new coverage.

Cost for *Preventive Services*

You may be eligible for some preventive services at no additional cost to you under the *Affordable Care Act (ACA)* and Virginia law

Q: Why are preventive services important?

A: Too many Americans do not get the preventive health care they need to stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce health care costs. Yet chronic diseases, such as heart disease, cancer, and diabetes, which are responsible for 7 of 10 deaths among Americans each year and account for 75% of the nation's health spending, often are preventable.

Q: How will the Affordable Care Act (ACA) and Virginia law affect my access to preventive services?

A: The ACA and Virginia law require many insurers to cover all *evidence-based*, recommended preventive services and eliminate *cost-sharing*. If you or your family enrolls in a *group health benefit plan* or an *individual health insurance policy* issued after March 23, 2010, your insurer will be required to provide coverage for certain recommended preventive services without charging you a *copayment*, *coinsurance*, or *deductible*.

Q: Which preventive services may I get at no additional cost?

A: Depending on your age, you may have free access to such preventive services as:

- Blood pressure, diabetes, and cholesterol screenings and tests;
- Many cancer screenings, including mammograms and colonoscopies (the test used to screen for colon cancer);
- Counseling from your health care provider on such topics as quitting smoking, losing weight, eating healthy, treating depression, and reducing alcohol use;
- Routine vaccinations against disease, such as measles, polio, or meningitis;
- Flu and pneumonia shots;
- Counseling, screening, and vaccines to ensure healthy pregnancies; and
- Regular well-baby and well-child visits from birth to age 21.

For a complete list of covered preventive services, go to:

http://www.healthcare.gov/law/about/provisions/services/lists.html.

For more information on staying healthy and about which covered preventive services are right for you based on your age, gender, and health status, ask your health care provider and check out: http://www.healthfinder.gov.

Q: Does this new preventive services rule apply to my *health benefit plan* or *policy*?

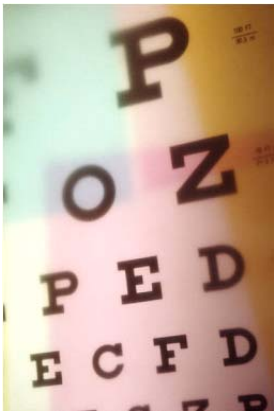
A: This preventive services provision applies to people enrolled under group health benefit plans and individual health insurance policies that are not grandfathered*. If applicable, this provision will affect you as soon as your health benefit plan or policy begins its first new *plan year* or *policy year* on or after September 23, 2010.

*** Refer to explanation on Page 17.**

If your group health benefit plan or individual health insurance policy was in existence or purchased on or before March 23, 2010, these benefits may not be available to you. Such plans or policies may be grandfathered* and exempt from this and other provisions of the ACA and Virginia law.

Q: Is there anything else in the fine print that I should know about preventive services?

A: • If your health benefit plan or policy uses a network of providers, be aware that your plan or policy is only required to cover these preventive services without cost sharing when provided by an *in-network provider*. Your health benefit plan or policy may allow you to receive these services from an *out-of-network* provider, but may require cost sharing.



• Your doctor may provide a preventive service, such as a cholesterol screening, as part of an office visit. Be aware that you maybe required to pay the costs of the office visit if the preventive service is not the primary purpose of the office visit or if your doctor bills you for the preventive service separately from the office visit.

*** Refer to explanation on Page 17.**

Choice of Health Care Providers

The *Affordable Care Act (ACA)* and Virginia law contain rules removing certain barriers between you and the doctor you may choose.

Q: How do the Affordable Care Act (ACA) and Virginia law affect my choice of doctors?

A: The ACA and Virginia law guarantee that you can choose the primary care doctor or pediatrician you want from your insurer's provider network. It ensures that you can see an OB-GYN doctor (a specialist in obstetrical or gynecological care) without a referral from another doctor. The law also guarantees that you can seek emergency care at a hospital outside your insurer's network without prior approval from your insurer.

Q: What does this mean for me?

A: You select the doctor: The new ACA and Virginia law permit you to choose any available participating primary care provider to be your primary care doctor. You can choose any available participating pediatrician to be your child's primary care doctor.

No barriers by your insurer to OB-GYN services: The new ACA rules also prohibit insurers from requiring a referral before you can seek care from a participating OB-GYN specialist.

Access to *out-of-network* emergency room services: The new ACA rules generally prevent *health benefit plans* or *policies* from having higher *copayments* or *coinsurance* for emergency room services that are obtained from a provider outside of your insurer's network. Insurers are also prohibited from requiring you to get prior approval before seeking emergency room services from a provider or hospital outside of your insurer's network.

NOTE: While the insurer is required to provide a reasonable reimbursement for emergency room services, you may still be responsible for the difference between the amount billed by the provider for out-of-network emergency room services and the amount paid by your insurer. This difference may result in a large bill for you to pay.

Did you know?

People who have a regular primary care provider:

Are more than twice as likely to receive recommended *preventive services*;

Are less likely to be hospitalized;

Are more satisfied with the health care system; and

Have lower costs.

Q: Will the choice of health care providers rules apply to my health benefit plan or policy?

A: These rules on choice of health care providers apply to all *group health benefit plans* and to all *individual health insurance policies* effective after March 23, 2010.

These new choice of health care providers rules **may not apply** to group health benefit plans and individual health insurance policies already existed on or before March 23, 2010, because these may be grandfathered*, or exempted from some provisions of the ACA and Virgina law.

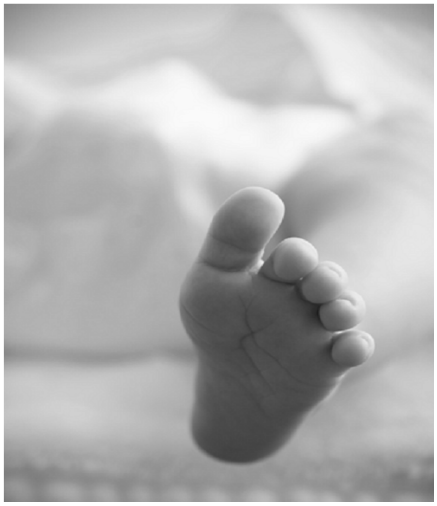
Q: When do these choice of health care provider rules take effect?

A: If your plan is not grandfathered, these protections will affect you when you start a new *plan year* or *policy year* beginning on or after September 23, 2010.

*** Refer to explanation on Page 17.**

Children With Pre-Existing Health Conditions

The *Affordable Care Act (ACA)* and Virginia law prohibit insurers from limiting or denying benefits for a child because of a health problem or disability the child had before the effective date of the *health benefit plan* or *policy*.



Q: What does this new rule on *pre-existing conditions* mean for my child?

A: Before the enactment of the ACA and Virginia law, some insurers could refuse to accept anyone because of a pre-existing health condition, or they could limit or exclude benefits for that condition.

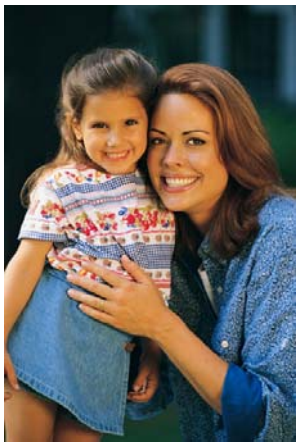
Under the ACA and Virginia law, most insurers cannot limit or deny benefits or deny coverage outright for a child younger than age 19 simply because the child has a pre-existing condition.

The new pre-existing health conditions rule protects coverage for your child, whether or not your child's health problem or disability was discovered or treated before your started coverage.

Q: Does this new rule on pre-existing conditions for children apply to my health benefit plan or policy?

A: This new rule on pre-existing conditions for children applies to all *group health benefit plans* and to *individual health insurance policies* you purchased after March 23, 2010.

This rule **may not apply** to an individual health insurance policy you purchased on or before March 23, 2010, because that plan may be grandfathered* or exempted from this part of the ACA and Virginia law.



*** Refer to explanation on Page 17.**

Q: When does this new prohibition on pre-existing conditions for children rule take effect?

A: The prohibition on *pre-existing condition exclusions* for children under 19 will apply to your health benefit plan or policy issued or renewed on or after September 23, 2010.

Q: How will the new rule prohibiting exclusions for pre-existing conditions for children affect medical care for my child?

A: If your child has a pre-existing condition, the new law can help your child receive health care coverage and benefits he or she might have otherwise been denied.

For example, on October 1, 2010, Sally purchased a new individual health insurance policy for herself and her child, 13-year-old Miranda, who has been treated for asthma in the past. Sally's new health policy excluded coverage for treatment of pre-existing conditions for all enrollees. On November 1, 2010, one month after coverage began for Sally and Miranda, Miranda was hospitalized for an asthma attack, and the insurance company denied payment for the hospitalization under the policy because Miranda's asthma was a pre-existing condition.

Under the new law, the insurer cannot deny payment for the hospitalization based on Miranda's pre-existing asthma condition because:

- Miranda is under the age of 19.
- Sally bought her individual health insurance policy after March 23, 2010, so her policy is subject to the pre-existing condition rules of the ACA.
- Sally's *policy year* began after September 23, when the law's rules on pre-existing conditions took effect.

Q: What about adults with pre-existing conditions?

A: The ACA states that these same rules prohibiting pre-existing conditions for children will apply to Americans of all ages starting with *plan years* or *policy years* that begin on or after January 1, 2014.

Adding Adult Children to Your Coverage

The *Affordable Care Act (ACA)* and Virginia law allow young adults to stay on their parents' *health benefit plans* or *policies* until age 26.

Q: What does this change to allow for adding adult children mean for my child?

A: Before the enactment of the ACA and Virginia law, insurers could remove enrolled children from the parent's plan when they became adults (usually at age 19, sometimes older for full-time students.) Now, most health benefit plans or policies that cover children must make coverage available to children up to age 26.

Q: Does this new rule on adding adult children apply to my health benefit plan or policy?

A: This rule affects health benefit plans or policies that offer coverage to dependent children. It applies to any health insurance policy you buy as an individual for yourself and your family. It also applies to all employer-based *group health benefit plans*, with one temporary exception: until 2014, some employer plans that predate the ACA are not required to let adult children stay on their parents' plans until age 26 if those children have another offer of coverage through an employer. Beginning in 2014, children up to age 26 can stay on their parents' employer health benefit plans even if they have another offer of coverage through an employer.

Q: When does this new rule permitting the addition of adult children to my health benefit plan or policy take effect?

A: Insurers are required to cover young adults for *plan years* or *policy years* beginning on or after September 23, 2010.

Q: Does my adult child have to live with me or be financially dependent on me to be eligible?

A: No. Your adult children can join or remain on your health benefit plan or policy whether or not they are married, living with you, in school, or financially dependent on you.

Q: When can I add my adult child to my health benefit plan or policy?

A: Insurers must provide children who qualify with an opportunity to enroll within 30 days of written notice of this opportunity. Written notice must be provided no later than the first day of the first plan or policy year beginning on or after September 23, 2010. Young adults and their parents need not do anything but sign up and pay for this option.

YOUR *Premium* Dollar

The *Affordable Care Act (ACA)* requires health insurers to spend your premium dollars primarily for direct medical care and quality improvements. Virginia law requires insurers offering *individual health insurance coverage* to spend your premium dollars primarily for medical health care. Both the ACA and Virginia law require health insurers to justify certain rate increase requests.

Q: What does the Affordable Care Act (ACA) require?

A: The new ACA rules require that a minimum percentage of your premium dollar be spent on direct medical care and quality improvements. Amounts spent on administrative costs, marketing, and other non health care-related costs are not allowed to be included in this percentage. If your insurer does not meet the minimum required percentage for health care and quality improvements for your type of product, it must provide a rebate to the policyholder. Your health insurer may also be required to provide justification for "unreasonable premium increases" to your State regulator or the Secretary of the U.S. Department of Health and Human Services.

Q: How does the ACA define "unreasonable premium increases?"

A: A rate increase is determined to be unreasonable if the increase is 10% or more, and (1) the increase means your insurer will not be spending the portion of your premium dollar the ACA requires (described below) on medical care and efforts to improve quality of care, (2) one or more of the assumptions on which the rate increase is based is not supported by substantial evidence, (3) your insurer provides data or documentation in connection with the increase that is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined, or (4) the rate increase results in premium differences between covered persons with similar risk factors that are not permissible under applicable State law or, in the absence of an applicable State law, do not reasonably correspond to differences in expected costs.

Q: What part of my premium dollar does the ACA require health insurers to spend on health care and quality improvements?

A:

- The ACA requires insurers to spend at least 80 % (and for large employer plans that are not *self-insured*, at least 85 %) of your premium dollars on direct medical care and efforts to improve the quality of care you receive.

- If you get your insurance from a large employer plan that is self-insured, these rules do not apply to you.

Q: How does this differ from what is currently required by Virginia law?

A: For individual health insurance coverage, Virginia law requires insurers to spend at least 60% of your premium dollars on direct medical care. Unlike the ACA, insurers cannot count amounts spent in efforts to improve the quality of care you receive as part of this minimum required percentage. Rates for individual health insurance coverage issued in Virginia that do not meet this threshold will be disapproved for use in Virginia.

For small group and HMO contracts, current Virginia law does not require health insurers to spend a certain amount of your premium dollar on direct medical care.

Q: When does the new ACA rule affect my *health benefit plan* or policy?

A: If the ACA rule applies to your plan or policy, it will affect you when you start a new *plan year* or *policy year* beginning on or after January 1, 2011.

Q: How do I know what my insurer spends my premium dollar on?

A: The ACA requires each health insurer to submit a report showing what that insurer spent on direct medical care and efforts to improve the quality of care during the year. The first reports are due by June 1, 2012, for the calendar year 2011, and it is anticipated that these will be posted on the Federal government's new national consumer Web site: www.HealthCare.gov.

Q: How do I get a rebate?

A: The rebate program under the ACA begins on January 1, 2011. Rebates, if required, would be paid beginning in 2012, and must be paid by August 1 of each year. Your plan will participate at the start of the first plan or policy year beginning on or after January 1, 2011. If you are owed a rebate, it may come in the form of a lump sum reimbursement or a reduction in your premiums. If your employer paid all or part of your premium or is the policyholder, all or part of any rebate may go to your employer as the policyholder. More details on the rebate program will be forthcoming from the federal government.

Are You Covered by a *Grandfathered Health Benefit Plan* or *Policy*?

If you have an *individual health insurance policy* that was in effect on or before March 23, 2010, your policy may be grandfathered. If you joined a non employment-based *health benefit plan* as the subscriber on or before March 23, 2010, your coverage may be grandfathered. If you are in an employment-based *group health benefit plan* that existed on March 23, 2010, your coverage may be grandfathered even if you enrolled in your plan after that date. Grandfathered health benefit plans and policies don't have to offer all the consumer protections that other plans have.

Q: What is the difference between a grandfathered health benefit plan or policy and other health benefit plans or policies?

A: Grandfathered health benefit plans or policies are exempt from some provisions of the *Affordable Care Act (ACA)* and Virginia law. Grandfathered individual health insurance policies are exempt from a few additional provisions of the ACA and Virginia law that apply to all other health benefit plans. Both employment-based group health benefit plans and individual health insurance policies may be grandfathered. An employment-based group health benefit plan that enrolled members on or before March 23, 2010 may be grandfathered, even if you or your family members didn't enroll until after that date.

Q: Are grandfathered health benefit plans or policies exempted from parts of the law forever?

A: A grandfathered health benefit plan or policy can lose this status if it makes significant changes that reduce benefits or increase costs to consumers. (See below for more information.)

Q: What immediate reforms apply to grandfathered health benefit plans or policies?

A: Many of the immediate reforms, which took effect on September 23, 2010, apply to all grandfathered health benefit plans or policies. Those protections applied at the start of the first new *plan year* or *policy year* after that date, which for most people was January 1, 2011.

At the start of the new plan year or policy year, health insurers:

1) Are prohibited from applying *lifetime dollar limits* to *essential benefits*.

2) Must not retroactively cancel your insurance coverage based on an unintentional mistake on an application.

3) Must allow children up to age 26 to stay on or be added to a parent's health benefit plan or policy as long as that plan or policy offers dependent coverage.

Note: Grandfathered group health benefit plans do not need to provide this benefit to dependents that have access to other employer-sponsored health coverage.

Q: Which immediate reforms DO NOT apply to grandfathered health benefit plans or policies?

A: Unlike other health benefit plans or policies, grandfathered health benefit plans or policies are not required to:

1) Provide certain recommended *preventive services* without charging the consumer a *copayment* for that service.

2) Offer new provisions for an appeals process for consumers who would like to appeal claims and coverage denials.

3) Remove certain barriers concerning your choice of primary health care providers and your access to emergency care, under federal requirements.

Q: Which immediate reforms DO NOT apply to grandfathered individual health insurance policies?

A: Grandfathered individual health insurance policies are not required to:

1) Phase out *annual dollar limits* on essential benefits.

2) Eliminate *pre-existing condition exclusions* for children under 19 years old.

(These protections DO apply to grandfathered group health benefit plans.)

Q: How does a health benefit plan or policy lose its grandfathered status?

A: Your health benefit plan or policy will no longer be grandfathered if:

1) It stops offering all or most benefits to diagnose or treat a particular condition, such as, diabetes, cystic fibrosis, or HIV/AIDS.

2) It increases the share of health services costs it requires you to pay; for example, from 20% of every hospital bill to 25%.

3) It increases the *deductible*, *out-of-pocket maximum*, or any *cost-sharing* other than a copayment, that was in effect on March 23, 2010, by more than a specified amount.

4) It increases your copayment — the flat fee that you must pay for a covered health care service — by more than a specified amount.

5) It imposes a new annual limit on the dollar value of all benefits or lowers an existing annual limit.

6) Your employer decreases the share of a health insurance *premium* it pays for you by more than five percentage points (for example, from 20% to 15%).

Note: Your insurer may increase your premiums and your health benefit plan or policy may still be considered grandfathered, as long as it doesn't make any of the changes listed above.

Q: How can I tell if my health benefit plan or policy is grandfathered?

A: 1) **Check your plan or policy materials**.Health benefit plans and policies must disclose their grandfathered status in any plan or policy materials in each new plan or policy year. Plan or policy materials are the documents your insurer gives you that describe the benefits it provides. These materials must also tell you who you can contact with your questions or complaints, and how to reach them. If this information is not includedin your plan or policy materials, your coverage could no longer be considered grandfathered.

2) **Check with your employer or your health benefit plan's benefits administrator**. If you are in an employment-based health benefit plan, the date you joined may not reflect the date that plan was created. New employees and new family members may be added to grandfathered group health benefit plans.

3) If you are enrolled in a grandfathered health benefit plan or policy, meaning significant changes should not occur to your plan or policy, but you experience significant changes in the benefits you receive and/or the costs you pay, you many contact the U.S. Department of Labor (for employment-based group health benefit plans) or the U.S. Department of Health and Human Services (for non employment-based health benefit plans and individual health insurance policies) to pursue questions and complaints. Your health benefit plan or health insurance policy must disclose how you may contact the appropriate agency.

Glossary of Terms

Important Note: The National Association of Insurance Commissioners (NAIC), an organization of insurance regulators from the 50 states, the District of Columbia and the five U.S. territories, has posted "Glossary of Health Insurance Terms" at its website at:
http://www.naic.org/documents/index_health_reform_glossary.pdf

The information provided below uses some of the terms and definitions posted on the NAIC's website as of June 24, 2011, except as noted below. Please refer to the website address above for the full glossary of health insurance terms and any updates to these terms and meanings.

-A-

ACA/Affordable Care Act*—The name given to the comprehensive health care reform law enacted on March 23, 2010. ACA is also known as the Patient Protection and Affordable Care Act (PPACA).

Annual dollar limit** — Many health benefit plans place dollar limits upon the claims the insurer will pay over the course of a plan or policy year. ACA and Virginia law prohibit annual dollar limits for essential benefits for plan or policy years beginning on or after Sept. 23, 2010, except for grandfathered policies providing individual health insurance coverage.

-B-

Balance billing** — When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for the unpaid amount. This is known as balance billing.

-C-

Coinsurance — A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.

Copayment** — A flat-dollar amount which a patient must pay when visiting a health care provider.

Cost-sharing** — Health care provider charges for which a patient is responsible under the terms of a health benefit plan or policy. Common forms of cost-sharing include deductibles, coinsurance, and copayments. Balance-billed charges from out-of-network physicians are not considered cost-sharing.

-D-

Deductible** — A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a health benefit plan or policy.

-E-

Essential Benefits** — ACA requires all health insurance plans sold after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care, and preventive services among other benefits. It also places restrictions on the amount of cost-sharing that patients must pay for these services.

Evidence-based* — Best practices determined by outcomes of scientific studies and research.

*This term and definition is not included in the NAIC's Glossary of Health Insurance Terms posted at its website.

**This term and/or definition has been modified from the NAIC's Glossary of Health Insurance.

-G-

Grandfathered health benefit plan or policy** — A group health benefit plan that existed on or before March 23, 2010 or individual health insurance coverage that an individual was enrolled in on or before March 23, 2010. Grandfathered plans or policies are exempt from many changes required by the ACA and Virginia law. New employees may be added to employment-based group health benefit plans that are grandfathered, and new family members may be added to all grandfathered individual health insurance policies, without removing the grandfathered status.

Group health benefit plan** — An employee welfare benefit plan that provides medical care for employees, including both current and former employees or their dependents directly or through insurance, reimbursement, or otherwise.

-H-

Health benefit plan** — A benefit plan that provides medical care for a group of participants or their dependents directly or through insurance, reimbursement, or otherwise.

Health Maintenance Organization (HMO) — A type of managed care organization (health benefit plan) that provides health care coverage through a network of hospitals, doctors, and other health care providers. Typically, the HMO only pays for care that is provided from an in-network provider. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

-I-

In-Network health care professional/In-Network provider** — A health care provider, such as a hospital or doctor, that has contracted to be part of the network for a managed care organization (such as an HMO or a PPO). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee.

Individual health insurance coverage/individual health insurance policy** — Health insurance coverage offered to individuals other than in connection with an employment-based group health benefit plan. ACA and Virginia law make numerous changes to the rules governing insurers offering individual health insurance policies.

-L-

Lifetime dollar limit** — Many health benefit plans or policies place dollar limits upon the claims that the insurer will pay over the course of an individual's life. ACA prohibits lifetime dollar limits on essential benefits beginning with plan years or policy years starting on or after September 23, 2010.

-O-

Out-of-network** — Care rendered by a health care provider (such as a hospital or doctor) that is **not** contracted to be part of a managed care organization's network (such as an HMO or PPO). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care out-of-network.

*This term and definition is not included in the NAIC's Glossary of Health Insurance Terms posted at its website.

**This term and/or definition has been modified from the NAIC's Glossary of Health Insurance.

Out-of-pocket maximum** — An annual maximum on all cost-sharing for which patients are responsible under a health benefit plan or policy. This limit does not apply to premiums, balance-billed charges from out-of- network health care providers or services that are not covered by the health benefit plan or policy.

-P-

Patient Protection and Affordable Care Act (PPACA)/Affordable Care Act (ACA)** — Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the health reform law.

Plan Year* — A 12-month period of benefits coverage which may or may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or contact your employer or insurer. For example: if your plan has a calendar plan year, the new rules would apply to your coverage beginning January 1, 2011.

Policy* —An individual health insurance policy.

Policy Year* — A 12-month period of benefits coverage under an individual health insurance policy which may or may not be the same as the calendar year. To find out when your policy year begins, you can check your policy documents or contact your insurer. For example: if your policy year is the same as the calendar year, the new rules would apply to your coverage beginning January 1, 2011.

Pre-existing condition* — Any physical or mental health condition, disability, or illness that existed for a person before that person applied for health care coverage.

Pre-existing condition exclusion** — The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition that existed for a person before that person applied for coverage. The ACA prohibits pre-existing condition exclusions for all plans beginning January 2014.

Preferred Provider Organization (PPO)** — A type of managed care organization that provides health care coverage through a network of providers. Typically, the PPO requires the policyholder to pay higher costs when they seek care out-of-network. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

Premium — The periodic payment required to keep a policy in force.

Preventive services** — Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. The ACA and Virginia law require insurers to provide coverage for preventive benefits without deductibles, copayments, or coinsurance.

-R-.

Rescind** — To void a health benefit plan or policy from its inception usually based on the grounds of material misrepresentation or intentional omission on the application for insurance coverage that would have resulted in a different decision by the health insurer with respect to issuing coverage. The ACA and Virginia law prohibit rescissions except in cases of fraud or intentional misrepresentation of a material fact.

-S-

Self-insured** — Group health benefit plans may be self-insured or fully insured. A plan is self-insured (or self-funded) when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurer.

*This term and definition is not included in the NAIC's Glossary of Health Insurance Terms posted at its website.

**This term and/or definition has been modified from the NAIC's Glossary of Health Insurance.