YOUR GUIDE TO HEALTH INSURANCE REFORM

for Individuals & Families

UPDATED in March 2013 with the latest on implementation of the Affordable Care Act (ACA)

This guide explains how Health Reform will affect Individual and Family health plans, helps you understand different types of health insurance and makes it easier to find the right plan for you and your family.

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HEALTH INSURANCE REFORM

On March 13, 2010, Congress passed – and President Obama signed into law – the Patient Protection and Affordable Care Act (PPACA). The law was amended on March 30, 2012 by the Health Care and Education Reconciliation Act. The name "Affordable Care Act (ACA)" is used to refer to the final amended version of the law, which has come to be known as Health Reform.

This law enacts changes to America's healthcare and health insurance systems that will take place over the next four years and beyond. These changes affect how both businesses and individuals buy health insurance.

INDIVIDUAL HEALTH INSURANCE is coverage you buy independently – rather than having coverage through an employer. It can be bought to cover a single individual or a family.

FOR INDIVIDUALS

Health Reform will

- Help people with pre-existing conditions get insurance.
- Let children stay on their parents' insurance until their 26th birthday.
- Place new requirements on health insurance plans, such as free preventive care.
- Prevent insurers from cancelling your policy when you get sick.
- Require every individual to have health insurance coverage.
- Create Health Insurance Exchanges in each state to make it easier to buy insurance.
- Expand Medicaid eligibility.
- Provide subsidies to help people afford health insurance.

FOR BUSINESSES

Health Reform will

- Provide tax credits for qualified small employers who buy health coverage for their employees.
- Require businesses with 50 or more full-time eligible employees to provide health insurance.
- Help employers pay some costs of early retirees' health insurance claims.

7 NEW BENEFITS FOR YOUR HEALTH INSURANCE PLAN

HERE'S TO GREAT HEALTH!

Health plans must now provide free access to preventive health services like:

- blood pressure and cholesterol tests
- cancer screenings like mammograms and colonoscopies
- counseling on quitting smoking, losing weight, treating depression, reducing alcohol use and more
- routine vaccinations
- flu and pneumonia shots
- well-baby and well-child visits
- pre-natal counseling

Health Reform means health insurance plans have new requirements and new restrictions on how they can operate.

1 **You can't be denied for a pre-existing condition.**
As of September 23, 2010, children under age 19 cannot be excluded from a policy because they have a pre-existing health condition. Beginning in 2014, no one can be denied coverage or charged more for insurance because they have a pre-existing health condition.

2 **Your policy can't be cancelled because you get sick.**
As of September 2010, you cannot be dropped from a policy when you get sick just because you made a mistake on your application. However, your policy can be cancelled if you don't pay your premiums on time or knowingly commit fraud on your application.

3 **Preventive care is covered at no additional cost.**
For policies purchased after March 23, 2010, you get free access to preventive services without paying a copayment, coinsurance or deductible.

4 **There's no lifetime limit on your benefits.**
For all plans issued after September 23, 2010, lifetime benefit limits (a limit on the amount your insurance company will pay) are prohibited. Annual benefit limits are also being restricted and phased out completely as of 2014.

5 **You have access to the doctors you want.**
For plans starting after September 23, 2010, you get to choose the primary care doctor or pediatrician you want from your plan's network of doctors and can see an OB-GYN doctor without a referral.

6 **No approval needed for emergencies away from home.**
Health plans can no longer make you get prior approval when you need emergency care at a hospital outside your plan's network.

7 **Your children can stay on your plan until they are 26.**
If your plan covers children, you can now add or keep your children on your health insurance policy until they turn 26 years old, even if they are married, not living with you or are financially independent.

Ask your broker about what's included in any health plan you're considering. Various changes to a plan could result in loss of grandfathered status. See this link for details: www.healthcare.gov/news/factsheets/keeping_the_health_plan_you_have_grandfathered.html.

PRE-EXISTING CONDITION INSURANCE PLAN

THE PCIP PROGRAM IS NOT ACCEPTING NEW ENROLLMENTS for applications received after March 2, 2013.

NEW UPDATE!

Following federal direction, beginning February 16, 2013, federally-run PCIPs suspended new enrollment. The California PCIP suspended new enrollments for applications received after March 2, 2013 until further notice.

Current PCIP subscribers are not affected by this change. However, subscribers need to pay their monthly PCIP premiums by the due date and continue to meet all eligibility requirements. Members who are disenrolled cannot be re-enrolled.

PCIP helps uninsured individuals with pre-existing conditions get affordable health insurance. The program has a limited amount of funding from Congress. Based on national experience and trends since the program began, PCIP enrollees have serious and expensive illnesses with significant and immediate healthcare needs. This enrollment suspension will help ensure funds are available for existing PCIP subscribers through 2013.

Note: If you lost PCIP coverage during the last six months because you moved out of state, you may be eligible to re-enroll in your new state of residence. Go to **http://www.pcip.ca.gov/PCIP_Program/PCIP_Eligibility_When_Moving_From_Another_State.aspx** for more information or call **(866) 717-5826 (TTY: 866-561-1604) Mon-Fri 8:00am-11:00pm EST** if you believe you are eligible.

Information and related materials are subject to change without notice.

The Pre-Existing Condition Insurance Plan (PCIP) was created as part of Health Reform to make insurance available for people who may have been denied coverage in the past because of a pre-existing health condition.

Depending on the state you live in, the PCIP program may be run by either the federal or state government. Many states already had a “high-risk pool” program in place before Health Reform. States can choose to either continue their own program or be part of the federal program run by the U.S. Department of Health and Human Services (HHS).

Updated as of March 19, 2013

NEW INSURANCE REQUIREMENT FOR INDIVIDUALS

STARTING IN 2014
EVERY AMERICAN MUST HAVE HEALTH INSURANCE

or pay a fee through your taxes

In June of 2012, the Supreme Court upheld the requirement of the ACA that every American must have health insurance – either through your employer, the government or an individually purchased plan – starting in 2014.

Exemptions are available for a variety of reasons and issued by the Exchange or the IRS. Tax credits and subsidies will also be available to help make insurance more affordable. While the ACA originally expanded Medicaid nationwide in order to provide coverage for lower-income individuals and families, the Supreme Court, in their decision, ruled states could opt-out of the Medicaid expansion program if they choose. This means many people who may have qualified for Medicaid will now, instead, receive subsidies to purchase insurance through a Health Insurance Exchange.

Reporting of compliance will be through the Internal Revenue Service, although procedures have not yet been finalized about who must report health insurance compliance and how.

FEES FOR NON-COMPLIANCE

YEAR	PER PERSON FLAT FEE		PERCENTAGE OF INCOME
2014	$95	or	1%
2015	$325	or	2%
2016	$695	or	2.5%

Fee is the greater of the two amounts. Dependents under the age of 18 will be assessed at a rate of half the standard fee.

THE INDIVIDUAL REQUIREMENT: PENALTY OR TAX?

Although the health reform law initially called the payment for not carrying health insurance a "penalty," in June 2012, the Supreme Court ruled that while Congress does not have the authority to apply a "penalty" for NOT doing something (i.e., buying insurance), they DO have the authority to levy a tax. There are still political disagreements about what to call the payment, so we have opted to use the term "fee" until the issue is officially resolved.

NEW
HEALTH INSURANCE EXCHANGES

A new way for individuals and businesses to buy insurance.

Starting in 2014, if you don't have health insurance through an employer, you will be able to buy it directly from a Health Insurance Exchange in your state. Exchanges will be competitive marketplaces where individuals and small businesses can compare and buy affordable health plans, similar to a health insurance shopping mall.

Exchanges will offer you a choice of plans that meet certain benefit and cost standards that have been outlined in Health Reform law. States can run Exchanges individually, groups of smaller states can band together to offer their residents better selection and pricing or a state can run an exchange jointly with the Department of Health & Human Services.

Tax credits and subsidies will be available to individuals and families to help them afford insurance through the Exchanges. Small businesses can also receive up to 50% of the cost of insurance premiums as a tax credit to help pay for coverage for their employees.

HOW TO BUY HEALTH INSURANCE

There are several ways you can find the right health insurance plan for your family as Health Reform takes shape.

INSURANCE BROKERS

Helping you find the best plans and prices

Regardless of the health reform opportunities that are developing, brokers will be a key way to get great information on the health insurance options that are available.

A licensed insurance broker can help you figure out which kind of plan would work best for your family's financial and healthcare needs, provide you with comparisons of available plans and help make the application and enrollment process go smoothly.

Brokers provide service on the policies they sell and can also help process claims or answer questions about your coverage. Brokers are paid a commission by the plans they sell, so you do not pay a fee for their services.

As Health Insurance Exchanges become operational, your insurance broker will be able to help you understand how the Exchange works in your state, find out if you are eligible for subsidies and work with you to claim any tax credits you may qualify for.

To find brokers in your area, visit:

www.nahu.org/consumer/findagent.cfm

ONLINE WEBSITES

Online comparisons help you shop with ease

Shopping online can make finding the right health insurance plan quick and easy. It helps narrow the choices if you have a basic idea of the type of plan you're looking for and a budget for what you want to spend.

One such online service is **www.healthcompare.com**. By answering a few easy questions, you can see a side-by-side comparison of the health plans available in your area, compare the benefits and features of each plan and even apply right online!

A similar service offering information Medicare-approved plans is **www.joppel.com**.

BUYER BEWARE

Be on the lookout for scams and shams when you shop for a health insurance plan.

Watch out for products that look like health insurance but don't provide the comprehensive coverage you expect from a quality plan.

Disease policies

These policies only pay for costs related to specific diseases like cancer. Most are extremely limited and don't provide you with good value for your money.

Accident policies

These policies only pay out when you have an accident. A quality health plan will cover both illnesses and accidental injuries.

Discount plans

While these products may offer you reduced costs on medical services from a list of providers and an ID card promising "coverage," discount plans aren't health plans and won't protect you from high medical expenses. And because these products aren't health insurance, they aren't policed by insurance regulators, so you may have trouble getting a refund if you don't get the discounts you were promised.

HEALTH INSURANCE TERMS YOU SHOULD KNOW

A "GRANDFATHERED PLAN" is a health plan that was in place before the Health Reform law (before March 23, 2010) and doesn't have to meet all of the new requirements for health insurance plans.

Annual Maximum The maximum amount your health plan will pay out over the course of a calendar year. Under Health Reform, the annual maximum amount will be gradually raised and phased out all together by 2014.

Copayment A flat fee you pay each time you receive service. For example, you might pay a $10 copayment each time you visit the doctor and a $150 copayment each time you are hospitalized.

Coinsurance The percentage amount you are responsible for paying after your deductible has been met. For example, in an 80/20 plan, the insurance company pays 80% of the charges and you pay 20%.

Covered expenses The services a health plan agrees to pay for. For example, if your plan pays for prescription drugs, it is a covered expense.

Deductible The amount of money you must pay each year before your insurance plan will cover any costs. For example, a plan with a $500 deductible means you have to pay for $500 worth of covered expenses before your plan will pay.

Exclusions Conditions or circumstances not covered under your plan. For example, a plan may exclude maternity services, which means that it will not pay for any costs related to a pregnancy or childbirth.

Formulary A health plan's list of medications that are covered under the plan.

Lifetime Maximum The maximum amount your health plan will pay out during the life of your plan. Most policies have both individual and family maximums. For policies written after September 23, 2010, lifetime maximums for essential health services are prohibited.

Maximum out-of-pocket The most money you would be required to pay annually for deductibles and coinsurance. For example, if your plan has a maximum out-of-pocket of $25,000 and you have a long-term hospitalization, once you have paid $25,000 in a year, the insurance company would pay the entire cost of medical expenses for the remainder of the year.

Pre-existing condition A health condition or illness for which you received treatment before your insurance became effective. Many health plans do not currently cover pre-existing conditions. Under Health Reform, as of 2014, you cannot be denied coverage for a pre-existing condition or charged more because of it. Until then, if you have been denied coverage because of a pre-existing condition, you may be eligible to purchase health insurance under a federal or state Pre-Existing Condition Insurance Plan (PCIP) program. See page 4 for details.

Premium The amount you pay monthly to get and keep an insurance plan.

Primary Care Physician The primary doctor who directs your care and refers you to specialists when needed.

Provider A general term that refers to anyone who provides you with health services. Providers can include doctors, hospitals, therapists, home health nurses, etc.

KNOW YOUR HEALTH PLANS

Understanding the differences between the primary types of health insurance plans can help you evaluate their benefits, understand their limitations and choose the best health plan for you and your family.

HMO Health Maintenance Organization. HMOs offer health services through a network of doctors, hospitals and other providers that are either employed directly by the plan or contracted through private physician groups. Most HMOs require you to choose a primary care physician who will oversee your care and make referrals to specialists when needed.

PPO Preferred Provider Organization. In a PPO plan, you can choose to get your care from the plan's contracted network of doctors or outside the network with doctors you choose. However, services from providers outside the preferred network usually require you to pay a higher copayment or percentage of the fee or both.

POS Point-of-Service. POS plans are a sort of hybrid between HMO and PPO plans. Similar to PPO plans, POS plans let you choose from in-network and out-of-network doctors for your care. However, like an HMO, you choose a primary doctor to direct your care.

HDHP High Deductible Health Plan. These are health plans where your annual deductible amount is fairly high (a minimum of $1,250 for individuals and $2,500 for families and up to $12,500 for family coverage), but they offer considerably lower premium costs. Once you have met the yearly deductible, plan coverage will begin. HDHPs typically offer you access to discounted rates with doctors and hospitals they have negotiated with to help lower the amounts you pay for medical services.

HSA Health Savings Account. Rather than a health plan, an HSA is a medical savings plan that lets you save money for current and future medical expenses on a tax-free basis. In order to be eligible for an HSA, you must be covered by a high-deductible health plan and not have any other insurance.

HEALTH PLAN COMPARISON

Use this list as a start to compare coverage and benefits between plans you are considering. Always talk to your broker and review the plan's benefits guide before you make a purchasing decision.

PLAN COVERAGE	AMOUNT
Yearly deductible	$ _____
Coinsurance (percent you pay)	% _____
Maximum out-of-pocket	$ _____
Annual maximum	$ _____
COPAYMENTS	
Office visit (primary)	$ _____
Office visit (specialist)	$ _____
Emergency room visit	$ _____
Hospital stay	$ _____
Pregnancy	$ _____
Prescription medications	
Preferred brand	$ _____
Non-preferred brand	$ _____
Generic	$ _____
Mail-order	$ _____

PLAN SERVICES	AMOUNT
Is the plan automatically renewable?	YES NO
Is there a limit on office visits?	YES NO
Can I get a second opinion?	YES NO
Do I need a referral to see a specialist?	YES NO

EXCLUSIONS (what the plan doesn't cover)

_____

STANDARDIZING HEALTH PLAN CHOICES

Starting in 2014, health insurance plans will be required to meet guidelines aimed at standardizing health plan choices for consumers. This is intended to make it easier to compare the benefits in different health insurance plans – and to also prevent insurance companies from only trying to attract the healthiest people.

In order to participate in a state or federal government Health Insurance Exchange, an insurance company will have to offer plans that fit within four levels of coverage, which are being called "metal" plans: **Bronze**, **Silver**, **Gold** and **Platinum**. A company doesn't have to offer plans in all four levels but does have to offer at least one Silver and one Gold plan.

Each plan must provide coverage for a set of minimum **Essential Health Benefits** that will include items and services in the following ten categories:

- Outpatient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive, wellness and chronic disease services
- Pediatric services, including oral and vision care

While each plan must cover the same *scope* of benefits, the *value* of these benefits will vary across the plan levels. For example Bronze plans will offer the least generous coverage with more out-of-pocket expenses, while Platinum plans will have more coverage with lower deductibles, lower copayments, etc. As a result, Platinum plan premiums will be the highest, with Bronze plan premiums the lowest. Plans will be compared using a measure called "actuarial value" that compares what percentage of health costs are covered by the plan. The chart at right gives you an idea of how the actuarial values will be applied to different plans levels.

EVALUATING HEALTH PLANS

Comparing health plans can be more involved than just looking at copayment and coverage amounts. Here are a few questions that can help you dig a little deeper.

What's the plan really going to cost me?

Look at the overall cost of the plan including premiums, out-of-pocket expenses, deductibles, coinsurance, etc.

What's the difference in cost in a "good" health year and a "bad" health year?

While a plan may seem affordable if you look at costs when you are in perfect health, you'll want to look ahead to the possibility that someone in your family may have a health issue that needs extended treatment. How does the plan measure up then?

What kind of providers does the plan use?

Look through the plan's provider directory so you can determine if the doctors you want to see are available under the plan. You should also explore the quality measures used for hospitals and physicians.

How does the plan compare on quality and service?

The Department of Health & Human Services (HHS) has selected the National Committee for Quality Assurance (NCQA) as the first official accreditation organization for health plans in Health Insurance Exchanges – more are expected to follow. Look at the plan's NCQA ratings to see how their customers feel about them, how many complaints they have and even what doctors think about the plan.

How easy is it to get service, deal with issues and get answers to my questions?

Does the plan have clear, simple explanations of the benefits and easy opportunities for you to determine if the plan is right for you? Is there a customer service line where you can get quick and straightforward answers to your questions? If a plan is not providing you with clear information before you've signed on, chances are filing claims and getting reimbursed for your expenses won't be very easy either.

PLAN LEVEL ACTUARIAL VALUES

PLAN LEVEL	INSURANCE COVERS	YOU PAY
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

NEW CHOICES FOR HEALTH COVERAGE

Beginning in 2014, individuals and families will be able to shop for and purchase health insurance coverage on government marketplaces called "exchanges" available in every state. You will be able to start enrolling in plans in October of 2013 with coverage effective January 2014.

PRIVATE HEALTH EXCHANGES offer consumers another choice for meeting the Individual Insurance Mandate.

Another option – **Private Health Insurance Exchanges** – is already available to help consumers shop for and purchase the right health insurance plan.

EXCHANGES PRIVATE VS. PUBLIC

Private health exchanges – operated by insurance brokers or insurance companies – give consumers another way to shop online for a variety of medical plans as well as supplemental insurance products like disability, dental and vision plans. These online portals make it easy to compare plans, shop for the best rates and even enroll.

Many private exchanges also offer "decision support" services that help you find the plan that best meets your family's needs. Private exchanges often include other benefit support services such as live operators to answer questions and provide assistance at renewal time.

Private exchanges can be offered by employers or utilized by individuals and families to purchase their own insurance. These online marketplaces also make it easy to expand your health coverage to add services not included in most major medical plans – like dental coverage, vision exams, chiropractic services and disability insurance.

MEDICARE CHANGES

Several reforms included in the Affordable Care Act are designed to improve the quality and reduce the cost of Medicare benefits for seniors.

Prescription Drugs

Medicare recipients who have Part D drug coverage now get a 50% discount on brand name drugs and a 14% discount on generic drugs when they reach the "donut hole" – where they must pay prescription drug expenses themselves. The hole will continue to shrink until 2020 when it will disappear completely and only usual co-payments will apply.

FREE Preventive Care

Seniors are now eligible to receive free cancer screenings, wellness visits, personalized prevention plans, vaccines, flu shots and more.

Medicare Advantage Changes

In an effort to reduce federal payments to Medicare Advantage plans run by private insurers, bonuses are now paid to insurers for quality and improved outcomes.

The Word & Brown Companies have been providing health insurance products to consumers and businesses for nearly 30 years. Our experience and expertise provides us with the unique perspective and ability to determine effective ways to continue to provide individuals and businesses with the best healthcare products at the best price.

Please note that there are many parts to Health Reform legislation and many of the specifics have yet to be worked out. Many are awaiting procedural guidelines from various government agencies including the IRS, Health & Human Services and individual states.

This guide highlights the areas of health reform that most impact individuals who do not receive insurance coverage from their employers – but instead purchase coverage for themselves and their family members on their own. We developed this guide as a resource to help individuals understand some of the changes enacted by health reform and how those changes may affect both their coverage and the way they purchase health insurance.

The information contained in this guide is not intended as specific legal, medical, financial or other advice. Every attempt has been made to ensure the accuracy of the information contained herein, according to general information currently available to the public regarding health reform legislation. This information is subject to change based on changes in the law or administration of the law.

This guide is intended to provide an overview of Health Reform. We recommend you contact a licensed health insurance broker to answer specific questions regarding changes to your benefits and how to select the best health plan for you and your family.

The Word & Brown Companies suggest each individual and business consult a licensed insurance broker and tax professional to understand the requirements under the health reform law specific to their individual circumstances and health conditions.

This guide has been provided courtesy of

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