



ConsumersUnion®
Health Reform:
The First Six Months

DISCOVER WHAT THE NEW LAW MEANS
FOR YOU AND YOUR FAMILY

A Note about Using this Guide: What's a Grandfathered Plan?

You'll see references to "grandfathered" and "non-grandfathered" (or new) plans. Put simply, grandfathered plans are those that existed when the health care reform law was signed on March 23, 2010, and that have not made significant changes in benefits causing them to lose this status. If they lose their "grandfathered" status, they must meet all the new provisions described in this guide. We've noted where new rules apply to all plans, or to just new or "non-grandfathered" plans.



SINCE ITS FOUNDING nearly 75 years ago, Consumers Union has been focused on providing consumers with easy-to-understand, accessible, and comparative information, so they can make the best decisions in the marketplace. Today, it's clear to us that the complex health-care marketplace is one which consumers need some of the greatest help. And while the new health-reform law has brought expanded opportunities for many, it's also brought a lot of confusion.

That's where we come in. To ensure consumers are well educated in how to take advantage of the new options available to them and their families, we've created a consumer guide. The goal is to help them—and you—understand those parts of the law that are taking effect now and to give actionable advice moving forward. We've included resources on the web where you can get reliable information.

We hope you find this guide useful. Additional copies are available for download from our website, ConsumerReports.org/health/insurance/health-insurance.htm, which will be updated frequently, so please be sure to check it out. The information is also available in Spanish at ConsumerReportsenEspañol.org/salud.

As always, we appreciate your feedback in our ongoing efforts to provide consumers with the information they need to make the choices they want.

A handwritten signature in black ink that reads "Jim Guest". The signature is written in a cursive, flowing style.

Jim Guest
PRESIDENT & CEO
Consumers Union
Publisher of Consumer Reports Magazine



“I have twins diagnosed with a condition called Spinal Muscular Atrophy. One of the things I have been most fearful of as a father is reaching our lifetime maximum.”

—Chris from Phoenix, AZ, recently discovered he won't have to worry about maintaining care for his twins' rare condition because of an end to lifetime benefit limits.

Ending Lifetime and Annual Benefit Limits

What's new?

Phase Out Annual and Prohibit Lifetime Limits

You may benefit if you:

- Are insured.
- Have a medical condition requiring expensive and/or ongoing treatment.
- Have reached an annual or lifetime limit in the past, or may do so in the future.

How it works:

- Lifetime limits are banned for all plans and annual limits will be phased out.
- If you've previously hit your annual or lifetime limit you'll again be able to access coverage.

The fine print:

- Annual limits are still allowed for the next three years, rising from \$750,000 to \$2 million before they are abolished in 2014.
- You'll have to wait for “open enrollment” or plan renewal for this benefit, which means you still may be subject to caps for several months.
- Phasing out annual limits only applies to group health plans and any “non-grandfathered” individual plans.

For more info:

ConsumerReportsHealth.org

Sick Children Can't be Denied Coverage

What's new?

Children Can't Be Denied Coverage for Pre-existing Conditions

You may benefit if you:

- Have a child under age 19 with a medical condition.
- Have a group plan or “non-grandfathered” individual plan.

What you get:

- Health insurers will be prohibited from denying coverage to children based on a pre-existing condition.
- Insurers cannot exclude treatments for pre-existing conditions.

The fine print:

- Applies to all existing employer plans, but only “non-grandfathered” individual plans.
- This is effective for plans beginning on or after Sept. 23, 2010. For many people, that will be in 2011.
- If allowed under your state's law, insurers may restrict enrollment in the individual market to specific open-enrollment periods or charge a higher premium.

For more info:

ConsumerReportsHealth.org



“The new law gives us peace of mind that we'll always be able to find health coverage for our daughter.”

—Nydia from Santa Clara, CA has a daughter who was born with a heart defect.



Extending Health Coverage to Teens and Young Adults

What's new?

Dependent Coverage Extended up to Age 26

Your child may benefit if:

- Your health plan offers family coverage.
- Your child is under age 26.
- Your child does NOT need to be financially dependent on you. Nor are they required to live with you, be unemployed, unmarried or a student.

"I was shocked when she was dropped from my coverage. Now we don't have to worry about insurance and she can focus on finishing college."

—Morris from Charlotte, NC recently discovered that he can add his daughter back onto his insurance coverage.

What you get:

- You'll be able to add your son or daughter to your policy until age 26.

The fine print:

- Some insurers and employers have already made this change but for others you may have to wait until the next "open enrollment" or your plan's renewal date.
- If you're in a "grandfathered" plan, your child only qualifies if he or she does not have an offer of health insurance through an employer. This restriction lasts until 2014.

HELP FOR EMPLOYERS TO COVER RETIREES

As of June 1, 2010, employers with retiree health plans can apply for financial assistance ("reinsurance") for a portion of retirees' high-cost health claims. In September the first 2,000 approved applicants were announced.

Reinsurance funds can be used by employers to help reduce costs for retirees, workers and their families, or to help companies offset their own insurance costs.

Medicare Changes

Closing the prescription drug "doughnut hole":

- If you fall into the "doughnut hole" and have to pay full price out-of-pocket for your medications, you'll get a \$250 check this year to help defray the costs. But you'll still have to pay any remaining costs while in the doughnut hole, potentially hundreds of more dollars.

- Starting in 2011, you'll get a 50% discount on brand-name drugs and reductions in the cost of generics in the doughnut hole. Each year the hole will get smaller, closing completely in 2020.

Preventive care costs:

- Starting on Jan. 1, 2011 seniors enrolled in Medicare or Medicare Advantage won't have to pay any out-of-pocket costs for preventive care such as mammograms, cancer screenings, and annual physical exams.

Changes to Medicare Advantage:

These provisions only affect the 1 in 4 seniors who have private Medicare Advantage plans.

- The extra payments that privately run insurance plans have been getting from Medicare will phase out over the next several years, starting in 2011. This could change your benefits or your costs for Medicare Advantage.

- By 2018, all private Medicare Advantage plans will get about the same amount per member as original Medicare spends. Advantage plans that provide high-quality care and services will get bonus payments.

For more info:
ConsumerReportsHealth.org

INSURERS CAN'T UN- FAIRLY CANCEL YOUR POLICY

What's new?

- Insurers will only be allowed to rescind (cancel) coverage as a result of fraud or an intentional misrepresentation.
- Previously insurers could retroactively cancel your insurance policy as a result of an unintentional error on your initial application.

The fine print:

- This provision applies to all insurance plans including group or individual policies, new and existing plans.
- All policies renewed after Sept. 23, 2010 are subject to this requirement.
- Insurers seeking to rescind coverage must provide at least 30 days advance notice to give people time to appeal.

For more info:
ConsumerReportsHealth.org

Health Coverage for People with Pre-Existing Conditions

What's new?

New Options for those with Pre-Existing Conditions

You may qualify if you:

- Have been uninsured for six months or more.
- Have a pre-existing medical condition.

What you get:

- Comprehensive coverage, such as primary care, ER visits and prescription drugs. Access to important protections such as no lifetime benefit caps.
- Premiums are tied to "standard" rates for people of similar health status, and can only vary by age and state (unlike existing state high-risk pools that may charge double the standard rate).

The fine print:

- In many states you must prove you've been denied coverage. And you wouldn't qualify if you were offered high-priced insurance but turned it down.
- Premiums vary by state and age and may still be pricey.

- Out-of-pocket cost sharing (co-pays and deductibles) is higher than with most major employers.

For more info: PCIP.gov

"I was very impressed with the knowledge they had and very impressed with the fact that as long as I pay my premium, I will have coverage."

—Sam from Myrtle Beach, SC, was uninsured until he signed up for the new Pre-Existing Conditions Insurance Plan.



YOUR NEW RIGHTS TO APPEAL DENIED CLAIMS

Consumers have the right to "appeal" when insurers don't pay for certain treatments. But how well this works varies widely, depending on your plan and the state you live in.

Here's how appeals processes are changing:

- Your health plan's internal appeals process must meet new standards, except "grandfathered" plans.
- In urgent medical cases, the insurer has to make a decision

on your appeal within 24 hours and has to continue covering your treatments while the appeal is pending.

- If your internal appeal is denied, you'll have the right to go to an independent external review board where the denial may be reversed.
- States have until July 1, 2011, to modify their appeals law and if they don't, the federal government will run an external appeals program in those states.



Small Business Tax Credits

“I found out I’m eligible for a 35% tax credit for the premiums I pay for my employees which makes it easier to keep offering coverage.”

—Ed from Franklin, NC owner of Franklin Fitness Center provides insurance to his employees but has struggled with annual rate increases.

What’s new?

Tax Credits for Small Businesses

A small business may qualify if it:

- Pays at least 50% of employees’ premiums.
- Has less than 25 full-time workers, or the equivalent (for example, an employer with fewer than 50 half-time workers may be eligible).
- Pays average salaries of less than \$50,000, not counting owner’s salary.

What small businesses get:

- A tax credit for up to 35% of what the employer spends on coverage (25% for non-profit employers).

- On Jan. 1, 2014, this credit increases to 50% (35% for non-profits).

The fine print:

- Business owners can only claim the tax credit for employees who are not family members. Owners and their family do not qualify.
- The amount of the credit varies by number of employees and average wages, so be sure to check out the details.

For more info:

SmallBusinessMajority.org/tax-credit-calculator/

Preventive Health Care and Screenings Covered

What’s new?

- Plans will be required to cover preventive services such as mammograms, annual physicals, and cancer screenings with no co-pays or deductible.

The fine print:

- Grandfathered plans do not have to comply with this provision. Only new policies or plans that have lost their grandfathered status must comply.

NEW WEBSITE: WWW.HEALTHCARE.GOV

H **HealthCare.gov** is a new, easy-to-use website with all of the private and public health insurance options available where you live, including:

- 5,600 private insurance plans offered by more than 1,000 companies in all 50 states and the District of Columbia.
- Medicare, Medicaid and the Children’s Health Insurance Program (CHIP).
- State high-risk pools and the new Pre-Existing Conditions Insurance Plans for people with medical conditions.
- Updated information about the health reform law and links to useful sites such as Medicare’s Hospital Compare, where you can compare the quality and safety of care at your local hospital.

More to come:

Here’s what you should look for in the coming year:

- Starting in January 2011, your health insurer must spend 80 to 85 cents of your premium dollar on actual health care and quality improvement, or you get a rebate.
- Also starting in 2011, state insurance regulators will have to determine if an insurance company’s rate increase is “reasonable” or not, which may slow premium increases.
- States will soon begin operating consumer assistance offices to help consumers find insurance options and solve disputes with their insurer.