GROUPS 2-50
GROUPS OF 51+
INDIVIDUAL & FAMILY PLANS

HEALTH CARE REFORM
COMMONLY ASKED QUESTIONS

Provided by:
Health Net, Inc.

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HEALTH CARE REFORM Q&A

On March 23, 2010, President Obama signed Senate bill H.R. 3590, The Patient Protection and Affordable Care Act, followed, on March 30, by The Health Care and Education Reconciliation Act of 2010 (H.R. 4872). The questions answered here concern implementation of these new health care reform provisions commonly known as "the Affordable Care Act."

Please note: This material is for informational purposes only. It should not be construed as compliance or legal advice. More information is available on the Health & Human Services (HHS) website: www.hhs.gov.

GENERAL QUESTIONS ON PROVISIONS AND TIMING

Q. What reforms are going to take place and what is the schedule for implementation?

A. The scope of the legislation is far reaching, and the schedule ranges from immediate implementation to regulations that won't be enacted until 2014 and beyond.

Among the provisions of the new legislation that became effective immediately are the following:

- *Review of "unreasonable rates."* The Health & Human Services (HHS) secretary will establish a process for the annual review of "unreasonable premium increases" in the group and individual markets. The term "unreasonable" has not yet been defined. Health plans must submit a justification for an increase prior to implementation. The secretary will also establish a program to award grants to states over a five-year period to carry out the review of premium increases. As a condition of receiving a grant, a state must provide HHS with information regarding trends in rating and premium increases.

- *"Grandfathered" plans.* A "grandfathered" plan is a group or individual health plan in which a person was enrolled on March 23, 2010. Grandfathered plans are exempt from some of the health insurance reforms. Generally, grandfathered health plans will be able to make routine changes to their policies and still maintain their status. These routine changes include making cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law or making changes to comply with state or other federal laws. Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers.

The legislation also establishes a number of "transition" programs. Among these are the following:

- *Internet portal.* By July 1, 2010, HHS was required to have created an Internet portal to facilitate consumer and small employers purchase of coverage. This will make information about options including access to public programs, high-risk pools and private market coverage readily available to the public. The Internet portal is now available at www.healthcare.gov.
- *Early-retiree reinsurance.* A temporary reinsurance program will reimburse employers for the cost of certain health benefits to retirees. Reinsurance amounts apply only to a percentage of certain claims between $15,000 and $90,000 for individuals between ages 55 and 64 who are enrolled in an early-retiree benefit program, are not active workers and are not Medicare eligible – along with their covered spouses and dependents. The program ends either on the date federal funding for the program is exhausted or on January 1, 2014, whichever is earlier.
- *National high-risk pool.* States (or HHS if the state declines to do so) must administer a pool for high-risk individuals until 2014. Individuals are eligible for high-risk pool coverage if they have pre-existing conditions and have not had creditable coverage for six months prior to applying for coverage with the pool.

Among the provisions that must be implemented this year (2010) are these:

- *Prohibition of lifetime limits and restriction on annual limits.* Health plans are prohibited from placing lifetime limits on essential health benefits and may establish a restricted annual limit only on the value of essential health benefits. Both provisions are directly tied to benefits defined as "essential" in the legislation; however, there is still ambiguity about what the essential benefits package includes.

- *Coverage for preventive services.* Plans must cover, without cost-sharing, a variety of preventive services as determined by organizations such as the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention.
- *Coverage for emergency services.* Plans covering emergency services must meet standards that include factors such as not requiring prior authorization, covering services from nonparticipating providers and not allowing out-of-network cost-sharing to exceed in-network rates.
- *MLR reporting.* Health plans must conform to an 80 percent Medical Loss Ratio (MLR) in the individual and small group markets and 85 percent MLR in the large group market, by 2011. Plans are required to pay rebates to enrollees if they fail to meet the requirement. The National Association of Insurance Commissioners (NAIC) will recommend uniform definitions for reporting categories and standardized methodologies to HHS.
- *Internal/External appeals.* Health plans must provide an internal process that follows applicable state law and any HHS requirements as well as give notice to enrollees of the external process for appeals of coverage determinations.
- *"Any willing participating provider."* Plans must allow members to designate their own participating primary care physicians (PCPs), OB/GYNs and pediatricians. Prior authorization or referral requirements for OB/GYNs are also prohibited.
- *No pre-existing conditions exclusions for children.* Plans are prohibited from excluding from coverage children with pre-existing conditions who are under 19 years of age.
- *Limitation on rescissions.* Insurers and group health plans may not rescind an enrollee's coverage unless the individual has performed an act that constitutes fraud against the plan or has intentionally misrepresented a material fact to the plan.
- *Over-age dependent coverage.* Group and individual market health plans providing coverage for dependent children must continue to make coverage available for an adult child until the child turns 26 years of age.

Q. Which provisions will be enacted later? What happens in 2014 and beyond?
A. Most of the more far-reaching provisions of the legislation do not take effect until 2014. These include the following:

- *The establishment of American Health Benefit Exchanges.* This provision requires states to establish "Exchanges" where individuals and small group employers (at least 50 and up to 100 full-time employees) can purchase coverage. State Exchanges may expand access to large groups beginning in 2017.
- *Prohibition of pre-existing conditions exclusions.* This prohibits group health plans and health insurers from imposing exclusions for pre-existing conditions.
- *Prohibition of excessive waiting periods.* This prohibits group health plans and health insurers from applying a waiting period that exceeds 90 days.
- *Prohibition on use of health status.* This prohibits establishing rules for eligibility (including continued eligibility) for an individual or dependent based on health status, medical conditions, claims experience, disability – any health-status-related factor as determined by the Secretary of HHS.
- *Guaranteed issue and guaranteed renewable.* Health insurers must accept any individual or employer group that applies for coverage during open or special enrollment periods. Further, they must renew coverage at the option of the individual or group.

Several of the reforms scheduled for 2014 concern pooling and risk-sharing. Among these are the following:

- *Transitional reinsurance program.* HHS and the states will establish a $25 billion transitional (2014 through 2016) reinsurance program for the individual market, to be funded by health insurers and third-party administrators on behalf of group health plans.
- *Risk corridors.* This provision establishes a risk corridor program for "qualified benefit plans" in the individual or small group market (2014 through 2016) based on the plan's ratio of allowable costs to aggregated premiums (modeled on the risk corridors under Medicare Part D for regional PPOs).
- *Risk-adjustment program.* This establishes a risk-adjustment process for the individual and small group markets that assesses a charge on issuers whose actuarial risk for a year is less than the average, and pays issuers whose actuarial risk for a year is greater than the average.

Reforms scheduled for 2014 also address plan options and benefits. Among these are the following:

- *Essential health benefits package.* HHS must define an "essential health benefits package," and coverage must fall into one of four benefit levels: Bronze, with an actuarial value of 60 percent; Silver, with an actuarial value of 70 percent; Gold, with an actuarial value of 80 percent; or Platinum, with an actuarial value of 90 percent. In addition, health plans offering coverage through an Exchange must offer a child-only policy (under age 21) and may offer a catastrophic-only policy to young adults (under age 30).

- *Clinical trials.* This provision prohibits the denial, limitation or imposition of additional conditions on coverage for "routine patient costs" associated with approved clinical trials.

There are numerous reforms scheduled for 2014 designed to address affordability. These include the following:

- *Tax credits for health insurance premiums.* This provision provides for refundable tax credits to individuals with incomes between 100 percent and 400 percent of the federal poverty level to cover purchases of qualified health plans on the Health Benefit Exchange.
- *Small employer tax credit.* This provides a tax credit for qualified small employers (those with no more than 25 full-time employees averaging annual wages of no more than $50,000) for contributions to purchase health insurance for their employees from a Health Benefit Exchange. Tax credits phase in beginning in 2011.
- *Cost-sharing assistance.* This provision reduces out-of-pocket maximum limits for those individuals with incomes between 100 percent and 400 percent of the federal poverty level.
- *Personal coverage requirement (individual mandate).* This provision requires that all U.S. citizens and legal residents must purchase insurance coverage or face a penalty (unless exempted from the mandate for reasons such as religious convictions, status below the income-tax-filing threshold, etc.).
- *Employer responsibility requirement.* Large employers (at least 50 employees) must pay a significant penalty if they do not offer health insurance coverage to employees.

Q. Is all of the legislation related only to benefits? Are there other provisions?
A. There are other provisions of health care reform that focus on administrative simplification, wellness programs and quality reporting. For example:

- *Administrative simplification.* HHS must adopt and regularly update standards and operating rules for the electronic exchange of information for financial and administrative transactions. HHS must also develop standards for use in providing enrollees with benefit summaries and coverage explanations.
- *Wellness programs.* This provision codifies and enhances provisions of the HIPAA nondiscrimination regulations that allow rewards to be provided to employees for participation in or for meeting certain health status targets related to a wellness program. It also allows health plans to provide a discount or rebate when an individual satisfies a standard related to a health factor.
- *Quality reporting.* HHS must develop annual reporting requirements with respect to plan benefits and health care provider reimbursement structures to improve quality. These reports will be published on a public website.

ACCESS TO EMERGENCY ROOM SERVICES

On June 28, 2010, the Departments of Health and Human Services, Labor, and Treasury released an interim final rule (IFR) on implementing provisions of the Affordable Care Act that address patient protections relating to emergency services.

Q. What are the new provisions related to emergency room services?
A. Plans that offer coverage for emergency room services:

- must provide access to services without requiring prior authorization,
- must *not* require that the health care provider be an in-network provider,
- must *not* impose any administrative requirements/limitations on benefits for out-of-network emergency services that are more restrictive than the requirements/limitations that apply to in-network emergency services; and
- must follow cost-sharing requirements where out-of-network cost-sharing is no greater than cost-sharing for services obtained at an in-network provider.

These rules do not apply to grandfathered plans.

Q. Are plans required to cover "balance billing" amounts?
A. Out-of-network providers may bill patients for the difference (the balance) between the providers' charges and the amount collected from the plan unless prohibited by state law. Plans are not required to cover balance billing amounts. The IFR does require that plans pay out-of-network providers a reasonable rate, which is defined to be the greater of the following:

- the amount negotiated with in-network providers for the emergency service furnished (if the plan has more than one negotiated amount with providers for a particular service, the basis for payment would be the median amount);
- the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing; or
- the amount that would be paid under Medicare for the emergency services.

[Note: Clarification has been provided that this methodology does not apply when balance billing is prohibited.]

Q. According to the Public Health Service Act, if a health plan or insurer provides emergency services benefits in a hospital emergency department, they must cover the services without regard to whether an in-network provider delivered the services and cannot impose any copayment or coinsurance greater than what would be imposed if services were provided in network. The statute does not require plans or issuers to cover amounts that out-of-network providers may "balance bill."

The IFR sets forth minimum payment standards to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient. Are the minimum payment standards intended to apply in circumstances where state law prohibits balance billing? Similarly, what if a plan or issuer is contractually obligated to bear the cost of any amounts balance billed, so that the patient is held harmless from those costs?

A. The minimum payment standards were developed to protect patients from being financially penalized for obtaining emergency services on an out-of-network basis. If a state law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums set forth in the regulations.

Similarly, if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy the payment minimums. In both situations, however, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts, to prevent inadvertent payment by the patient. Nonetheless, even if state law prohibits balance billing, or if the plan or issuer is contractually responsible for amounts balance billed, the plan or issuer may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.

CHOICE OF HEALTH CARE PROFESSIONALS

On June 28, 2010, the Departments of Health and Human Services, Labor, and Treasury released an interim final rule (IFR) on implementing provisions of the Affordable Care Act that address patient protections relating to choice of health care professionals.

Q. How does the IFR affect the choice of a primary care physician (PCP)?
A. The IFR provides that a group health plan or insurer that allows or requires a member to choose a primary care physician must allow the choice of *any participating* primary care physician who is available to accept the member. Similarly, the plan or insurer that allows or requires a member to choose a primary care physician for children enrolled in the plan must also allow the choice of *any participating* pediatrician who is available to accept the member. This rule does not apply to grandfathered plans.

Q. What are the new provisions relating to OB/GYN services?
A. The IFR requires that plans and insurers providing access to OB/GYN services must also allow access, without a referral, to an OB/GYN. The plan must provide individuals with notice of these requirements whenever a plan or issuer provides participants with a summary plan description or other similar description of benefits under the plan or health insurance coverage. In the individual market, notice must be provided whenever the plan provides a primary subscriber with a policy certificate or contract of health insurance. A model for the notice is provided in the IFR.

CONTINUOUS COVERAGE FOR OVER-AGE DEPENDENTS

The new policy applies to all commercial medical policies for groups and individuals sold by Health Net or Health Net Life Insurance Company in Arizona, California, Oregon and Washington, *including* COBRA, state-specific COBRA and out-of-state plans. It does not apply to Medicare or Medicaid policies. Because current benefit plans for Health Net of the Northeast already include coverage up to at least age 26 for dependents, no modifications are needed for Health Net of the Northeast.

Please note: Health Net extended the option of retaining adult over-age dependents on existing policies prior to the September 23, 2010, effective date of the provision. However, not all employers and individuals chose to take advantage of this option.

Group Employer and Member Questions

Q. What must we [employers] do to take advantage of this option for our members to continue coverage for over-age dependents?
A. If you are a plan administrator, contact your broker or Health Net representative for details. If you are an employee with a group policy, please contact your plan administrator to determine if your group adopted coverage for over-age dependents in advance of their renewal on or after September 23, 2010.

Q. Which over-age dependents qualify for coverage?
A. If the employer group notified Health Net prior to May 31, 2010 that it wished to elect the option to continue coverage for existing enrolled dependents, dependents with birthdays in April 2010 and later did not age-off their parents' plans until their 26th birthday. For groups opting in after May 31, 2010, the over-age dependents were retained from the month the group opts in.

Q. What is the process for implementing coverage for over-age dependents?
A. Employers should notify their Health Net account representative in writing (email, fax, etc.). Upon receiving the request, the Health Net account manager is responsible for submitting a Group Sales Notification (GSN) requesting existing enrolled dependents be covered up to age 26. For groups that opted, between May 1 and May 31, 2010, to continue dependents' coverage, coverage continued for dependents who aged-off their parents' plans in April 2010 or later. For groups that opted in for continued dependent coverage on June 1, 2010 or later, the effective date is the first of the following month.

Birthday month	First opt-in month
April	May
May	May
June	June
July	July
August	August
September	September

Example: For a group requesting continued dependent coverage on June 10, 2010, coverage for dependents who would have terminated July 1, 2010, due to a June birthday, will be retained.

Q. Is there any impact to an employer if we do not continue coverage for over-age dependents?

A. There will be no impact until federal health care reform provisions regarding dependent coverage go into effect upon the employer group's first renewal on or after September 23, 2010. At that time, dependents up to age 26 may be added to their parents' policies during open enrollment or upon renewal. Until then, current policies and procedures regarding over-age dependents apply.

Q. If my dependent aged-off my policy prior to May 1, 2010, or has never been on my plan, may I add him or her now?
A. Now that the overage health care mandate is in effect (as of September 23, 2010), eligible dependents, until their 26th birthday, may be added to their parents' policies upon the employer group's renewal. [Note: For plan years beginning before January 1, 2014, a grandfathered group health plan may exclude an adult child if the adult child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.]

Q. I was recently hired by a new employer, and I have an over-age dependent under 26. Will my dependent be covered under my policy?
A. Not at this time. Health Net's early adoption of federal provisions regarding dependent coverage is for existing enrolled dependent members only. Enrollment will be an option upon your employer group's next renewal occurring on or after September 23, 2010, and assuming your dependent is still under age 26.

IFP Member Questions

Q. How do I continue coverage for a dependent already on my policy?
A. Contact a Health Net Customer Service Representative for more details at the following numbers:

- In California: 1-800-909-3447 option 3, option 3
- In Oregon and Washington: 1-888-802-7001 option 1, option 9
- In Arizona: Please call the telephone number listed on your Health Net identification card.

Q. Which over-age dependents qualify for coverage?
A. If the individual notifies Health Net prior to May 31, 2010 that he or she wishes to elect the option to continue coverage for existing enrolled dependents, dependents with birthdays in April 2010 or later will not age-off their parents' plans until their 26th birthday. For individuals opting in after May 31, 2010, the over-age dependents will be retained from the month the individual opts in.

Q. If my dependent aged-off my policy prior to May 1, 2010, or has never been on my plan, may I add him or her at this time?
A. Dependents, until their 26th birthday, may be added to their parents' policies, subject to medical underwriting guidelines. [Note: For plan years beginning before January 1, 2014, a grandfathered group health plan may exclude an adult child if the adult child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.]

Q. What happens if I don't elect to continue coverage for my over-age dependent?
A. As of September 23, 2010, dependents up to their 26th birthday may rejoin under their parents' policies at anytime.

GRANDFATHERED PLANS

As Federal health care reform was being debated, many Americans expressed the desire to keep the health plans they currently have. In order to address this concern, The Affordable Care Act provided for "grandfathered" plans. While the law requires all health plans to provide certain new benefits to consumers, it allows plans that existed on March 23, 2010 (the Affordable Care Act effective date), to make routine changes without losing grandfather status. Plans lose their grandfather status only if they choose to significantly cut benefits or increase out-of-pocket spending for consumers.

The Departments of Health & Human Services (HHS), Labor, and Treasury have issued Interim Final Rules that specify how grandfathered status will be defined and maintained. When final rulings are issued, answers to these questions may change.

Q. What is a "grandfathered" plan?
A. A grandfathered health plan is an existing group health plan or health insurance coverage (including coverage from the individual health insurance market) in which an individual was enrolled on March 23, 2010. That means that as long as an individual was enrolled in a particular health insurance plan on March 23, 2010, that plan has grandfathered status.

Q. What insurance reforms are imposed on grandfathered plans?
A. Grandfathered health plans are exempt from the vast majority of the new insurance reforms. However, grandfathered plans are subject to a handful of requirements with different effective dates.

For plan years beginning on or after the Affordable Care Act effective date (March 23, 2010), all grandfathered health plans must comply with the following reforms:

- Development of uniform explanation of coverage documents
- Reporting of medical loss ratio and other financial information to the HHS secretary of Health and Human Services, and offering of premium rebates to enrollees if the plan did not meet specified medical loss ratios (Rebate offers begin no later than January 1, 2011.)

Grandfathered *group* health plans will be required to comply with the following reforms for plan years beginning on or after September 23, 2010:

- Prohibition on lifetime limits on essential health benefits.
- Prohibition on health plan rescissions.
- Requirement to extend dependent coverage to children until the individual is 26 years old. Prior to 2014, a child may enroll for dependent coverage in a grandfathered plan only if the individual is not eligible for employment-based health benefits.

Grandfathered *group* health plans will be required to comply with the following reforms for plan years beginning on or after January 1, 2014:
• Prohibition on waiting periods greater than 90 days.

Grandfathered *group* health plans are required to comply with the following reforms for plan years beginning on or after September 23, 2010:
• Restriction on annual limits on essential health benefits.
• Prohibition on coverage exclusions for pre-existing health conditions for children under age 19.

Grandfathered *group* health plans will be required to comply with the following reforms for plan years beginning on or after January 1, 2014:
• Prohibition on coverage exclusions for pre-existing health conditions.

Q. What types of changes can a plan make without losing grandfathered status?
A. Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include making cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with state or other federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

Compared with their policies in effect on March 23, 2010, grandfathered plans:

- *Cannot significantly cut or reduce benefits.* For example, a plan cannot choose to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS and maintain grandfathered status.
- *Cannot raise coinsurance charges*. Typically, coinsurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.

- *Cannot significantly raise copayment charges.* Frequently, plans require patients to pay a fixed dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those copays by no more than $5 (adjusted annually for medical inflation) *OR* a percentage equal to medical inflation plus 15 percentage points, whichever is the greater of the two.
- *Cannot significantly raise deductibles.* Many plans require patients to pay the first bills they receive each year (e.g., the first $500, $1,000 or $1,500 invoiced that year). Compared with the deductible required as of March 23, 2010, grandfathered plans can increase these deductibles only by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4 to 5 percent, so this formula would allow deductibles to go up, for example, by 19 to 20 percent between 2010 and 2011, or by 23 to 25 percent between 2010 and 2012. For a family with a $1,000 annual deductible, this would mean if they had a hike of $190 or $200 from 2010 to 2011, their plan could then increase the deductible again by another $50 the following year.
- *Cannot significantly lower employer contributions.* Many employers pay a portion of their employees' premium for insurance, and this is usually deducted from employees' paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15 percent to 25 percent).
- *Cannot add or tighten an annual limit on what the insurer pays.* Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit.
- *Cannot change insurance companies.* If an employer decides to buy insurance for its workers from a different insurance company, the new plan will not be considered a grandfathered plan. This does not apply when employers who provide their own insurance to their workers switch plan administrators nor does it apply to collective bargaining agreements.
- *Cannot restructure the company.* Employers cannot conduct a merger, acquisition or similar business restructuring if the principal purpose of the action is to cover new individuals under the grandfathered plan.
- *Cannot move employees to a plan with lesser benefits.* Cannot force employees to switch to another grandfathered plan that has fewer benefits or higher cost-sharing unless there is a bona fide employment-based reason for the change. Reducing the employer's costs is not a bona fide reason.

Among the changes that will not result in the loss of grandfathered status are the following:

- Changes in premiums.
- Addition of family members of an individual who is enrolled in a grandfathered plan.
- Addition of new employees (whether newly hired or newly enrolled) in a grandfathered plan.
- Disenrollment of one or more individuals enrolled on March 23, 2010, (provided that the plan or coverage has continuously covered at least one person since March 23, 2010).
- Changes required to conform to federal and state laws and regulations.
- Voluntary adoption of consumer protections as articulated in the new reform laws or increases in benefits.
- Changes in a third-party administrator (TPA).

Q. How does the law prevent health plans from using grandfathered status to avoid providing various consumer protections?

A. To prevent health plans from using grandfathered status to avoid providing important consumer protections, the regulation provides for the following:

- *Disclosure*. Every time it distributes plan materials, a grandfathered plan must disclose to consumers that it believes it is a grandfathered plan and, therefore, it is not subject to certain consumer protections of the Affordable Care Act. This allows consumers to understand the benefits of staying in a grandfathered plan or switching to a new plan. The plan must also provide contact information for enrollees to have their questions and complaints addressed.
- *Revocation of status.* If a health plan forces consumers to switch to another grandfathered plan that, compared with the current plan, has fewer benefits or higher cost-sharing as a means of avoiding new consumer protections, grandfathered status will be revoked. It is also revoked if a plan is bought by or merges with another plan simply to avoid complying with the law.

Q. Does a change in a plan's prescription drug formulary or the addition or deletion of a physician to the plan's network cause the plan to lose grandfathered status?

A. Neither the term "network" nor "formulary" is mentioned directly in the grandfathering regulations, nor does it appear that a plan could lose grandfathered status because of a network change. However, grandfathered status is lost if a plan eliminates all or substantially all of the benefits to diagnose or treat a specific condition. For example, a grandfathered plan that provides benefits for a

particular mental health condition that include a combination of counseling and prescription medicine would lose grandfathered status upon the elimination of the counseling benefit.

Although the legislation does not specifically reference changes to prescription drug formularies, it may be assumed that the elimination of one drug from a formulary, of which there are alternative drug options, would not result in a loss of grandfathered status. Further, a plan could likely replace a brand-name prescription drug with a generic alternative without losing grandfathered status. These questions are being raised in the requests for comments on the government's Interim Final Rules.

Q. How might a merger/acquisition affect grandfathered status?
A. The regulation states that if the principal purpose of a merger, acquisition or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan. The goal of this rule is to prevent grandfather status from being bought and sold as a commodity in commercial transactions.

There is a second anti-abuse rule that addresses a situation under which employees who previously were covered by a grandfathered health plan are transferred to another grandfathered health plan. This rule is intended to prevent efforts to retain grandfathered status by indirectly making changes that would result in loss of that status if those changes were made directly.

Q. Are there other regulations outside of the Affordable Care Act with which grandfathered health plans must comply?
A. A grandfathered health plan must continue to comply with regulations and laws that were applicable prior to the changes enacted by the Affordable Care Act except to the extent where those laws and regulations were supplanted by changes made by the Act. Therefore, the HIPAA portability and nondiscrimination requirements and the Genetic Information Nondiscrimination Act requirements applicable prior to the effective date of the Affordable Care Act continue to apply to grandfathered health plans. In addition, the mental health parity provisions, the Newborns' and Mothers' Health Protection Act provisions, the Women's Health and Cancer Rights Act and Michelle's Law continue to apply to grandfathered health plans.

Q. How does grandfathered status apply to collective bargaining agreements?
A. In the case of health insurance coverage maintained pursuant to a collective bargaining agreement made before March 23, 2010, the coverage is a grandfathered health plan at least until the date on which the last agreement relating to that coverage terminates, even if there is a change in insurers during the period of the agreement. After the date on which the last of the collective bargaining agreements terminates, the determination of whether the health insurance coverage continues as a grandfathered plan is made by comparing the terms of the coverage on the date of determination with the terms of the coverage that were in effect on March 23, 2010. A change in issuers during the period of the agreement, by itself, would not cause the plan to cease to be a grandfathered health plan.

Q. If we (an employer) add a plan as an option for employees to select in addition to a grandfathered plan, do we now maintain one grandfathered plan and one non-grandfathered plan?
A. Yes. For example, an employer offering two grandfathered benefit plans may change the health insurance issuer for one of the plans. That plan loses grandfathered status. However, if the second plan has not been subject to one of the changes that cause a plan to lose grandfathered status, the employer will have one grandfathered plan and one non-grandfathered plan.

Q. If we (an employer) have maintained two grandfathered plans but eliminate one – thus forcing employees to consolidate into the other grandfathered plan – does that plan retain grandfathered status?
A. Whether a plan retains grandfathered status depends on whether there was a "bona fide employment-based reason to transfer the employees to the other plan." An example of a bona fide reason is when an employer maintains separate plans at separate facilities, but one facility closes and the employer consolidates all employees in one plan. However, reducing cost is not a bona fide reason.

Q. Does enrollment in a grandfathered health plan meet the individual mandate requirement?
A. Yes. The individual mandate requires most individuals to have health insurance beginning in 2014, or potentially pay a penalty for noncompliance. Individuals will be required to maintain minimum essential coverage for themselves and their dependents. The Affordable Care Act defines minimum essential coverage to include many different insurance options, including grandfathered plans.

On a practical level, the question concerning grandfathered plans and complying with the individual mandate is relevant only to plans in the individual market. A person enrolled in any employer plan, whether the plan has been grandfathered or is new, will have met the individual mandate.

INTERNAL REVIEW AND EXTERNAL APPEALS PROCESS

The U.S. Departments of Health and Human Services (HHS), Labor, and the Treasury have released Interim Final Rules (IFRs) on implementing section 2719 of the Affordable Care Act with respect to internal review and external appeal processes. In general, the IFR applies to group health plans and health insurance coverage issued in the group and individual markets for plan (or policy years) on or after September 23, 2010. The IFR does not apply to "grandfathered" health plans.

General questions concerning internal review

Q. What is an "adverse benefit determination"?
A. An adverse benefit determination includes a rescission of coverage as well as any denial, reduction or termination of, or failure to provide or make a payment for, a benefit based on any of the following criteria:

- a determination of an individual's eligibility to participate in a plan or insurance coverage;
- a determination that a benefit is not covered by the plan or insurance;
- the imposition of limits on covered benefits such as a pre-existing condition or source-of-injury exclusion; or,
- a determination that a benefit is experimental, investigational or not medically necessary or appropriate.

Q. What are the time constraints surrounding adverse benefit determinations?
A. Plans and insurers are required to notify individuals of an adverse benefit determination within the time frames established by state or federal law (e.g., the ERISA claims rule).

Q. What are the time constraints surrounding denial of an urgent care claim?
A. Denial of an "urgent care claim" must be provided as soon as possible, but no later than 24 hours after the receipt of the claim. An urgent care claim is any claim for medical care to which the application of the time periods for making non-urgent determinations could either:

- seriously jeopardize the life or health of the individual or their ability to regain maximum function; or
- subject the individual to severe pain that cannot be managed with the care or treatment that is the subject of the claim (in the opinion of a physician with knowledge of the individual's medical condition).

Q. What information must be included in the notice of an adverse benefit determination?
A. The notice of an adverse benefit determination must include the following information:

- An identification of the claim that includes:
  - the date of service,
  - health care provider,
  - claim amount, and
  - applicable diagnosis and treatment codes (and code meanings).
- The reason for the adverse determination, including any denial code and description of the standards used to deny the claim.
- A description of the available internal appeals and external review processes.
- Contact information for a state office of health insurance consumer assistance or ombudsman that is established pursuant to section 1002 of the Affordable Care Act.

The IFR also imposes new standards for determining when a plan or insurer must provide notices in languages other than English.

Q. What are the rules regarding an internal review process?
A. Group health plans and insurers must allow the claimants to review the claim file and to present evidence and testimony as part of the internal review process. Claimants must be provided, free of charge, any new or additional evidence considered, relied upon or generated in connection with the review prior to the date of determination. In addition, coverage of the claimant must be continued pending the outcome of an internal review or external appeal. Further, pending the outcome of an internal review or external appeal, plans or issuers cannot reduce or terminate benefits for ongoing courses of treatment without providing advance notice or opportunity for review.

Group health plans and group insurers may provide two levels of internal review of an adverse claim determination; however, in the case of an insurance issuer in the individual market, only one level of internal review is permitted before an external appeal. All records associated with the process must be maintained for six years and must be available to the claimant and state or federal oversight agencies upon request.

Q. Are there rules regarding the associates handling the internal review?

A. Yes. The rule stipulates that an internal review of an adverse benefit determination must be made in a manner that ensures the independence and impartiality of the person making the decision. This means that Health Net may not provide payment to, or make employment decisions regarding a reviewer (e.g., a claims adjudicator or medical expert) based on the likelihood that the individual will support a denial of benefits.

Q. What happens if a plan or issuer fails to adhere to the requirements set forth in the Interim Final Rules?
A. If a plan or issuer fails to adhere to the Interim Final Rules' requirements with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process.

General questions concerning external appeals

Q. Are the rules regarding the external appeals process at the state or federal level?
A. If a state external review process has adopted the consumer protections in the National Association of Insurance Commissioners (NAIC) Uniform Model Act; then insurance issuers must comply with that state review process, and are not required to follow the federal external review process.

Q. What are the rules regarding the external review process?
A. The Interim Final Rule requires state external review processes to include the following provisions:

- Individuals must be permitted to request external appeals to consider adverse benefit determinations involving decisions regarding medical necessity, appropriateness, health care settings, levels of care or effectiveness of a covered benefit. This includes external review of adverse benefit determinations involving experimental or investigational treatment.
- Insurers and plans must provide written notice to claimants of their rights in connection with the external review.
- If the state process requires exhaustion of internal claims and appeals processes, exhaustion is not necessary where the issuer or plan has waived the requirement or where the claimant has filed for expedited external and internal review at the same time.
- Claimants may only be assessed a nominal fee (not to exceed $25) for filing an external appeal. That fee must be returned to the claimant if the adverse benefit determination is reversed through external review.
- There may be no restriction on the minimum dollar amount of a benefit denial that may be submitted for appeal.
- Claimants must be allowed at least four months to submit an appeal after receipt of notice of an adverse benefit determination from the plan or insurer.
- Independent Review Organizations (IROs) must be assigned on a random basis or other basis that assures the independence and impartiality of the review organization.
- IROs used must be accredited and a list of such approved IROs qualified to conduct external reviews must be provided by the state.
- Claimants must be notified and provided at least five business days to submit additional written information to the IRO for consideration.
- The IRO must provide the claimant and insurer or plan written notice of its decision no more than 45 days after receipt of a request for external review.
- The IRO decision is binding on the parties, "except to the extent … other remedies are available under state or federal law."
- A process for expedited appeals must be available for decisions involving urgent care claims and emergency services.
- Issuers or plans against which a request for external review is filed must pay the cost for the IRO.
- IROs must maintain written records and make them available to appropriate parties upon request.

Q. What is the timing for compliance with the external review process?
A. For group health plans and insurance issuers offering group and individual health care coverage that are already complying with existing state external appeals processes, the Interim Final Rule provides for a transition period. However, for plan and policy years after July 1, 2011, the state external review process must meet the minimum federal standards set forth by Health and Human Services (HHS)

Q. Can a member request review on a claim from the past? What is the deadline?
A. The Interim Final Rule does not specifically address claims from the past; however, it does refer to the established Department of Labor claims review procedures. Under those requirements, as part of a full and fair review, claimants must be given 60 days within which to appeal following the receipt of notification of an adverse benefit determination. Based on this, it seems unlikely that plans would be required to review claims older than 60 days.

Questions concerning timing of implementation

Q. New provisions regarding internal review and external appeals processes are effective September 23, 2010. Implementation is a tremendous task – what happens if we aren't prepared to implement on time?
A. On September 20, 2010, the U.S. Department of Labor issued a technical release regarding implementation of the appeals provisions of the reform laws. The release sets forth an enforcement grace period until July 1, 2011, in order to give group health plans and group and individual market insurers more time to implement procedures and make changes to computer systems in order to comply fully.

Specifically, the release cites an enforcement safe harbor for provisions of the IFR regarding the following:

- the 24-hour time frame for making urgent care claims decisions,
- the provision of notices in a culturally and linguistically appropriate manner,
- broader content and specificity in notices – including the addition of CPT and ICD codes, and
- the provision stating that if a plan or issuer fails to strictly adhere to all the requirements of the IFR, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process and may proceed to external review or any other remedy provided under ERISA or state law.

The Department of Labor, the Internal Revenue Service and the Department of Health and Human Services will not take any enforcement action during the grace period against a plan or issuer that is "working in good faith to implement such additional standards but does not yet have them in place." In addition, HHS is encouraging states to provide similar grace periods (presumably as state regulators enforce provisions applicable to fully insured plans).

LIFETIME AND ANNUAL LIMITS ON BENEFITS

On June 28, 2010, the Departments of Health and Human Services, Labor, and Treasury released an interim final rule (IFR) on implementing the Affordable Care Act provisions that address application of lifetime and annual limits on benefits.

Questions concerning lifetime and annual limits on benefits

Q. What are the basic rules concerning lifetime and annual limits on benefits?
A. The interim final rule prohibits group health plans and group and individual insurers from establishing any lifetime limit on the dollar amount of benefits for any individual. In addition, they may establish only "restricted" annual limits on "essential health benefits." (See below.)

Q. When do these provisions go into effect?
A. The provisions are effective for plan years (in the individual market, policy years) on or after September 23, 2010.

Q. Do these provisions apply to grandfathered plans?
A. Yes. The annual and lifetime limit provisions apply to "grandfathered" group health plans and group insurers. The requirements with respect to the prohibitions on lifetime limits, but not those with respect to annual limits, apply to individual insurance market grandfathered coverage.

Q. What are "essential health benefits"?
A. The Department of Health & Human Services (HHS) must define the term "essential health benefits" for reforms scheduled for 2014. In the interim and according to the IFR, the Department will take into account "good faith efforts" by group health plans and insurers to comply with a reasonable interpretation of the term "essential health benefits" for purposes of applying "restricted" annual limits for plan years that begin on or before January 1, 2014. The allowance for good faith efforts by a plan or insurer is intended to "fill the gap" until the essential health benefits are defined by HHS.

A plan's interpretation of "essential health benefits" must be consistent for purposes of applying the Affordable Care Act lifetime and annual limits. Consequently, a plan cannot both apply a lifetime limit to a particular benefit – taking the position that it was not an essential health benefit – and at the same time treat that particular benefit as an essential health benefit for purposes of applying the restricted annual limit.

Q. What approach is Health Net using to define "essential health benefits"?
A. In order to determine a reasonable definition for "essential health benefits" while awaiting forthcoming official guidance from HHS, Health Net analyzed typical benefit offerings for HMO and PPO plans as well as mandated state benefits for states where we

conduct business: California, Arizona, Oregon and Washington. Further, we reviewed mandated state benefits nationwide before determining our final list of "essential health benefits."

Q. How does the rule address "non-essential" benefits?
A. The IFR acknowledges that annual and lifetime limits are allowed for non-essential benefits and permits exclusion of all benefits for a particular condition (i.e., it does not consider an exclusion to be an impermissible annual or lifetime limit).

Q. Are there any special considerations for individuals who have already reached a lifetime limit and, as a consequence, lost coverage?
A. The rule establishes transitional reinstatement rules for certain individuals who have reached a lifetime limit and lost coverage. The individuals must be notified of their re-enrollment rights and provided a 30-day open enrollment period. The IFR requires these individuals to be treated as "special enrollees."

In the individual insurance market, the reinstatement requirement appears to be limited to situations in which a family member is still enrolled in coverage (e.g., one spouse reached the lifetime limit, but the other spouse still has coverage).

Q. A prohibition on annual limits begins in 2014. Are there any interim provisions?
A. To mitigate the potential for premium increases, the rule adopts a three-year phase-in approach for the "restricted" annual limits to smooth the transition to the 2014 prohibition. The limitations apply on a per individual basis (so each covered person on the policy has his or her own limit).

The annual limits on the dollar value of essential benefits may not be less than the following:

- For plan years beginning on or after September 23, 2010, but before September 23, 2011 – $750,000
- For plan years beginning on or after September 23, 2011 but before September 23, 2012 – $1.25 million
- For plan years beginning on or after September 23, 2012, but before January 1, 2014 – $2 million.

Note: Annual dollar limits for essential benefits are prohibited beginning in 2014.

Q. Are there any exceptions to "restricted" annual limits on essential health benefits?
A. There is a process for group health plans and group and individual insurers to submit a request for a waiver from the annual benefit limit restrictions for plans or policies that were offered prior to September 23, 2010, and which have a plan or policy year beginning between September 23, 2010, and September 23, 2011. The application may be submitted electronically and include the following information:

- The terms of the plan or policy form.
- The number of individuals covered by the plan or policy form.
- The applicable annual limits and rates.
- A brief description of why compliance with the annual limit restrictions would result in a significant decrease in access to benefits or significant increase in premiums.
- An attestation, signed by the plan administrator or chief executive officer certifying that the plan was in force prior to September 23, 2010 and that the application of the annual limit restrictions would result in a significant decrease in access to benefits or significant increase in premiums.

For plan or policy years that begin before November 2, 2010, applications must be submitted not less than 10 days before the start of the plan/policy year. For plan or policy years that begin after November 2, 2010, applications may be submitted not less than 30 days prior to the beginning of the plan or policy year.

The Department of Health and Human Services (HHS) will process applications within 30 days of submission (10 days in the case of applications for policy years beginning before November 2, 2010). Waiver approvals from HHS will be applicable for one year, and new applications must be submitted for subsequent plan or policy years.

Q. Do these provisions apply to limited benefit ("mini-med") plans?
A. The HHS secretary may waive the restrictions on annual limits for "limited benefit plans" or so-called "mini-med" plans if compliance with the IFR would result in either a "significant" decrease in access or benefits or a "significant" increase in premiums.

The preamble indicates that HHS will be issuing guidance "regarding the scope and process for applying for a waiver" in the near future.

Q. How do these provisions apply to HSAs, MSAs, HRAs and other arrangements or accounts?
A. The IFR exempts flexible spending arrangements from the restrictions on annual limits. In addition, the preamble clarifies that health savings accounts (HSAs), medical savings accounts (MSAs) and health reimbursement arrangements (HRAs) are not subject to the requirements. (The rule does apply, however, to any high-deductible health plans offered in conjunction with an HSA, MSA or HRA). The preamble to the IFR also makes clear that a "stand-alone" HRA provided under a retiree-only health plan is not covered by the requirements.

PREVENTIVE SERVICES

Background information
Among the insurance reforms required by the Affordable Care Act are those related to preventive services. The regulations apply to group health plans and health insurance coverage issued in the group and individual market, and are effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010. The regulatory requirements do not apply to health plans with grandfathered status.

Overall, the regulations require coverage for a broad category of preventive services including immunizations, blood pressure and cholesterol screenings, diabetes screening for hypertensive patients, various cancer and sexually transmitted infection screenings, depression screenings, tobacco cessation programs, obesity screening and counseling, as well as other services. Plans can no longer charge a patient a copayment, coinsurance or deductible for these services when they are delivered by an in-network provider.

Q. What preventive services must be covered and who makes that determination?
A. Overall, the regulations require coverage for all of the following items and services without imposing any cost-sharing requirements (e.g., a copayment, coinsurance or deductible):

- evidence-based items or services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP);
- evidence-informed preventive services and screenings for infants, children and adolescents as detailed in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- evidence-informed preventive services and screenings for women as detailed in comprehensive guidelines supported by the HRSA and not otherwise addressed by the recommendations of the USPSTF. (HHS is developing these guidelines and expected to issue them no later than August 1, 2011.)

Q. Can you provide more information about the three organizations making recommendations?
A. The U.S. Preventive Services Task Force (USPSTF) is the leading independent panel of private-sector experts in prevention and primary care. It conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services.

The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) consists of experts in fields associated with immunization, who have been selected by the Secretary of the U.S. Department of Health and Human Services to provide advice and guidance on the control of vaccine-preventable diseases.

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

Q. The recommendations from the U.S. Preventive Services Task Force (USPSTF) refer to A and B ratings. What does that mean?
A. The Task Force grades the strength of the evidence from "A" (strongly recommends), "B" (recommends), "C" (no recommendation for or against), "D" (recommends against), or "I" (insufficient evidence to recommend for or against). The Interim Final Rule on Preventive Services specifies using USPSTF-recommended items or services with a rating of A or B.

Q. Do plans with grandfathered status have to cover the mandated preventive services?
A. No. These regulatory requirements regarding preventive services do not apply to grandfathered health plans.

Q. Where can I find a complete current list of preventive services to be covered under the new law?
A. A complete list of covered preventive services is available at www.HealthCare.gov/center/regulations/prevention.html.

Q. To what extent are plans able to determine coverage limitations for recommended preventive services, e.g. ,limitations in terms of frequency, method of delivery, treatment practices, etc.?
A. To the extent they are not specified in the recommendation or guideline, plans will be permitted to use reasonable medical management techniques to determine the frequency, method, treatment or setting for which the preventive items or services will be available without cost-sharing requirements.

Q. Can a plan deny coverage for preventive services not specified by the organizations making recommendations?
A. Yes. Plans or issuers are permitted to deny coverage for items or services that are not recommended by the United States Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention or in the guidelines provided by the Health Resources and Services Administration.

Q. Must plan members use an in-network provider to receive recommended preventive services without cost-sharing?
A. Yes. Plans are not required to provide coverage for recommended preventive services delivered by out-of-network providers. In these situations, plans may impose cost-sharing requirements for any recommended preventive services.

Q. Some plans cover preventive services beyond those recommended by the USPSTF, HRSA or the ACIP. Must those be covered without cost-sharing, too?
A. Many plans cover preventive services that go beyond those recommended by the USPSTF, HRSA or the ACIP. Both the statute and the Interim Final Rule allow plans the option to cover preventive services that are in addition to those required. For such additional preventive services, plans may impose cost-sharing requirements. In addition, a plan or issuer may impose cost-sharing requirements for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

Q. Are there any recommendations that did not have the September 23 deadline for implementation?
A. Yes. For recommendations that have been in effect for less than one year, plans will have one year from the effective date to comply. These include the following recommendation from the United States Preventive Services Task Force (USPSTF):

- Screening and counseling for obesity in children (in effect January 31, 2010)

And recent recommendations from the Advisory Committee on Immunization Practices (ACIP) include the following:

- Meningococcal vaccine (in effect September 25, 2009)
- HPV (in effect January 8, 2010)
- Influenza (in effect March 2, 2010)
- Pneumococcal vaccine (in effect March 12, 2010)
- Combination measles, mumps, rubella and varicella vaccine (in effect May 7, 2010)

Note: Health Net already covers the above under our immunization benefit.

Q. What is the timeline for adding any new recommendations?
A. Generally, plans must provide coverage for current recommended preventive services for plan years that begin on or after September 23, 2010. When new recommendations are issued, an interval of not less than one year between the date the recommendation is issued and the plan year/policy year for which coverage of such services must be in effect will apply.

Q. What guidelines for preventive services specifically for children have been outlined?
A. Health plans must cover preventive services for children as recommended under the *Bright Futures* guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics. These guidelines provide pediatricians and other health care professionals with recommendations on the services they should provide to children from birth to age 21 to keep them healthy and improve their chances of becoming healthy adults. The types of services that will be covered include regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.

Q. Does coverage of preventive services apply to Medicare members?
A. Yes. The Patient Protection and Affordable Care Act provides for preventive services without cost-sharing under Medicare. On June 25, 2010, the Department of Health and Human Services (HHS) issued new rules to eliminate cost-sharing for recommended preventive services delivered by Medicare and to provide Medicare coverage – with no copayment or deductible – for an annual wellness visit that includes a comprehensive health risk assessment and a 5- to 10-year personalized prevention plan, starting in 2011.

Q. Does coverage of preventive services extend to Medicaid members?
A. The Affordable Care Act provides enhanced federal Medicaid matching funds to states that offer evidence-based preventive services for Medicaid members.

PROHIBITION OF DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS

The nondiscrimination requirements of the Internal Revenue Code that were previously applied only to self-funded group health plans have been extended by the Affordable Care Act to include most insured group health plans. These rules prohibit employers from discriminating in favor of highly compensated individuals relative to rank-and-file employees with respect to eligibility to participate in a group health plan and to benefits provided under that plan.

Ensuring compliance with new nondiscrimination rules may be challenging for employers. The information provided here is for informational purposes only and should not be construed as compliance or legal advice. Employers are advised to seek their own counsel or tax advice to resolve any uncertainties about compliance.

Q. Do the new rules apply to grandfathered benefit plans?
A. No. A plan that has grandfathered status does not have to comply with the new nondiscrimination rules as long as the plan maintains grandfathered status.

Q. When do the new rules go into effect?
A. The new nondiscrimination requirements are effective for plan years beginning on or after September 23, 2010. Again, note that the Affordable Care Act makes an exception for "grandfathered health plans" from the new nondiscrimination rule for as long as the plan maintains grandfathered status.

Q. What is the definition of "highly compensated individuals"?
A. The foundation for the Affordable Care Act nondiscrimination requirements are found in section 105(h) of the Internal Revenue Code of 1986. For purposes of section 105(h), highly compensated individuals are generally defined as one of the five highest-paid officers, a shareholder who owns 10 percent or more stock of the employer and/or an individual who is among the highest-paid 25 percent of all employees.

Q. In what areas is discrimination prohibited?
A. The Affordable Care Act rules prohibit discrimination in favor of highly compensated individuals relative to two areas: discrimination with respect to eligibility and discrimination with respect to benefits provided under the benefit plan.

Q. What requirements must be met relative to eligibility?
A. Benefit plans cannot discriminate in favor of highly compensated individuals as to eligibility for participation. In order to meet the nondiscrimination requirements related to eligibility, plans must satisfy any one of the following three requirements:

- The plan benefits 70 percent or more of all employees.
- 70 percent or more of all employees are eligible to benefit under the plan, and at least 80 percent of those who are eligible do, in fact, benefit.
- The plan benefits a nondiscriminatory classification of employees.

In meeting their eligibility requirements, group health plans are permitted to exclude certain employees from consideration, such as those who have not completed three years of service or those who are not yet 25 years old.

Q. What requirements must be met relative to benefits?
A. Benefit plans satisfy the nondiscrimination requirements only if all benefits provided for highly compensated individuals are also provided for all other plan participants. Optional benefits may be offered if all eligible participants may elect the benefit and if the required employee contributions are the same amount.

Q. Do the new rules mean that our company will not be able to continue our executive medical benefit plan?
A. If the executive medical benefit plan maintains its grandfathered status, it will not be subject to these new provisions; however, it will need to be compliant with all other health care reform provisions that apply to grandfathered plans.

Q. Do the new rules apply to retiree-only plans?
A. It appears that the Affordable Care Act nondiscrimination rules do not apply to retiree-only plans; however, to the extent that a fully insured group health plan covers both current and former employees, the rules do apply.

Q. How do we determine if our plan is meeting the requirement for nondiscrimination?

A. Testing is available to help benefit plans determine whether they are meeting eligibility and benefit requirements. While final regulations in this area have not been issued, qualified tax professionals can help employers determine if their plans are compliant with provisions of the Internal Revenue Code and the Public Health Services Act that provide the basis for the Affordable Care Act requirements. Health Net does not provide testing services.

Q. Who is responsible for ensuring compliance with the nondiscrimination rule – the employer group or Health Net?
A. The legal and regulatory documents require a "group health plan" to satisfy the non-discrimination provisions of Section 105 of the IRS Code relating to highly compensated individuals. The term "group health plan" is defined as any plan or program that is created or maintained by an employer or by an employee organization, or by both, for the purpose of providing medical benefits for its participants or their beneficiaries, through the purchase of insurance. The term "group health plan" specifically does not include health insurance issuers offering group or individual health insurance coverage. That means that it is the responsibility of the employer sponsor of the group health plan to ensure compliance.

Health Net's disclaimer on prohibition of discrimination in favor of highly compensated individuals

Q: What is Health Net's approved disclaimer and recommended language regarding the prohibition of discrimination in favor of highly compensated individuals?
A. Health Net's approved disclaimer is as follows:

> If your plan is grandfathered, it is exempt from the nondiscrimination provision. If your plan is *not* grandfathered, health care reform requires compliance with section 105(h) of the IRS code of 1986, which provides that if a group health plan "discriminates," as that term is defined in the code, in favor of "highly compensated employees," some or all of the value of the contributions made by the employer to purchase the "highly compensated employee's" health insurance may be included in the "highly compensated employee's" income and thus is taxable. Please let your Health Net account manager know if we need to discuss changes to your current plan offerings based on this provision.

PROHIBITION ON PRE-EXISTING CONDITIONS EXCLUSION FOR CHILDREN

On June 28, 2010, the Departments of Health and Human Services, Labor, and Treasury released an Interim Final Rule (IFR) prohibiting group health plans and insurers in both the group and individual markets from imposing pre-existing condition exclusions on children under 19 for the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. For individuals age 19 and older, this prohibition is applicable for plan years (or in the case of insurers of individuals, policy years or applications denied) on or after January 1, 2014.

These regulations apply to grandfathered group health plans and group health insurance coverage but do not apply to grandfathered individual health insurance coverage. For non grandfathered individual health insurance policies children under 19 cannot be denied coverage because of a pre-existing condition for policy years beginning on or after September 23, 2010.

The IFR also changes the current definition of pre-existing condition exclusion to include a denial of coverage and applies the requirements to individual health coverage provided to certain individuals with prior group coverage.

Questions concerning children 19 years of age and under

Q. Will children in child-only, individual market health plans be affected by the new access to these plans for children with pre-existing conditions?
A. Child-only insurance plans that existed on or prior to March 23, 2010, and that do not significantly change their benefits, cost-sharing and other features, will be "grandfathered" or exempt from these regulations. As such, children enrolled in grandfathered child-only plans on or before March 23, 2010 are unlikely to be affected by the new policies.

Q. Do insurers in the individual market have to offer children under age 19 non-grandfathered family and individual coverage at all times during the year?
A. No. To address concerns over adverse selection, insurers in the individual market may restrict enrollment of children under 19, whether in family or individual coverage, to specific open enrollment periods, if allowed under state law. This is not precluded by the new regulations.

For example, an insurance company could set the start of its policy year for January 1 and allow an annual open enrollment period from December 1 to December 31 each year. A different company could allow quarterly open enrollment periods. Both situations assume that there are no state laws that set the timing and duration of open enrollment periods.

Q. How often must an insurer in the individual market provide an open enrollment period for children under 19?

A. Unless state laws provide such guidance, insurers in the individual market may determine the number and length of open enrollment periods for children under 19 (as well as those for families and adults). The administration, in partnership with states, will monitor the implementation of this policy and issue further guidance on open enrollment periods if it appears that their use is limiting the access intended under the law.

Q. How do these rules affect existing enrollment requirements in states that already require guaranteed issue of coverage for children under age 19 in the individual market?
A. If a state requires continuous open enrollment or requires insurers to maintain an open enrollment period of a particular length, or open enrollment periods of a particular frequency, then the state requirement will apply. The state law is not pre-empted by any current federal requirements.

Q. What steps can insurers take to mitigate adverse selection from newly offering child-only health insurance on a guarantee-issue basis?
A. A number of actions have been suggested by insurance commissioners and insurers to address adverse selection in child-only policies. The following actions are not precluded by existing regulations:

- Adjusting rates for health status only as permitted by state law (Note: The Affordable Care Act prohibits health status rating for all new insurance plans starting in 2014).
- Permitting child-only rates to be different from rates for dependent children, consistent with state law.
- Imposing a surcharge for dropping coverage and subsequently reapplying if permitted by state law.
- Instituting rules to help prevent dumping by employers to the extent permitted by state law.
- Closing the book of business for current child-only policies if permitted by state law.
- Selling child-only policies that are self-sustaining and separate from closed child-only books of business if permitted by state law.

In addition, some states are considering legislation that would require individual-market issuers that offer family coverage to also offer child-only policies. This approach could increase the options for families with healthy as well as sick children and would lower the risk of adverse selection.

Q. How many annual open enrollment periods for children under age 19 in the individual market will Health Net implement? What will the duration be of the open enrollment period?
A. Health Net is in the process of establishing open enrollment periods for children under age 19. We expect more details in the near future as state and federal regulations are clarified.

Q. Will Health Net continue to accept applications for coverage for children under age 19 in the individual market before we commence with open enrollment (OE) periods?
A. Until the regulations and procedures are clarified and our OE periods begin, we will not be accepting applications for coverage for children under the age of 19. When OE begins, we will begin accepting applications for children. Applications for children's coverage that already are in-house, and which were not approved by September 22, 2010, will no longer be considered. [Note: In Oregon, Health Net is seeking approval to offer IFP plans and rates with effective dates on or after Oct. 1, 2010. We expect to begin accepting applications there when we receive state approval.]

This change will not affect:

- Those currently enrolled in child-only plans.
- Those currently enrolled in employer-sponsored plans.
- Those currently enrolled with their parents on a family plan.
- Enrollment of HIPAA-eligible children who meet the requirements for guaranteed-issue coverage.
- The addition of newborns and adopted children to existing family plans that include child dependent coverage.

We continue accepting applications for family plan coverage for dependents 19 to 26 years of age.

Questions concerning individuals between 19 and 26 years of age

Q. Can insurers deny coverage in the individual market to dependents with pre-existing conditions between the ages of 19 and 26?
A. For individuals age 19 and older, the prohibition on pre-existing conditions exclusion is applicable for plan years (or in the case of insurers of individuals, policy years or applications denied) on or after January 1, 2014. Until then, medical underwriting can take place, and coverage can be denied.

RESCISSION OF HEALTH INSURANCE POLICIES

On June 28, 2010, the Departments of Health and Human Services, Labor, and Treasury released an interim final rule (IFR) implementing provisions of the Affordable Care Act addressing restrictions on rescissions.

Q. What is a "rescission"?
A. The IFR defines a "rescission" as a cancellation or discontinuance of coverage that is retroactive.

Q. When does the rule regarding rescission go into effect? Does it apply to grandfathered plans?
A. The IFR applicable to rescissions will be effective for plan years beginning on or after September 23, 2010, and will apply not only to new coverage, but also to all grandfathered health plans.

Q. Under what conditions is rescinding a policy permitted?
A. The IFR prohibits group health plans and insurers offering group or individual coverage from rescinding a policy, contract or plan with respect to an individual once the individual is covered, except in the following two situations:
- the individual performs an act, practice or omission that constitutes fraud; or
- the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

Q. In cases where rescission is permissible, what notice is required?
A. In situations where a rescission is permissible, a plan or issuer is required to provide a minimum 30 days written notice to each participant that will be affected before the coverage can be rescinded. Notice requirements apply whether the rescission affects an individual, an individual within family coverage or an entire covered group.

Q. Can states establish additional standards concerning rescissions?
A. Yes. The IFR specifies that the rescission provision is a federal baseline. States (and other federal provisions) may establish additional standards that are even more protective of individuals.

Q. What is Health Net's approach to rescinding coverage?
A. In 2007, Health Net was the first health plan in the nation to halt rescissions without third-party review. On April 30, 2010, Health Net publicly reaffirmed the policy.

Health Net will only rescind coverage when a member has engaged in fraud or has made intentional misrepresentation of material fact in order to obtain insurance.

In addition to halting rescissions, Health Net has also:
- undertaken the extensive processes of ensuring its applications and underwriting processes are clear and understandable, and obtaining all necessary information before issuing a policy;
- implemented heightened broker reviews, training and education; and
- adopted a committee structure to review possible rescissions and provide members with ample opportunity to respond prior to the final decision.

GENERAL QUESTIONS ABOUT MEDICARE

Q. What is the impact of reform legislation on Medicare Advantage and/or Part D?

A. The following reforms will impact Medicare Advantage (MA) plans and Part D plans:

- *Medicare Advantage plan payments.* Medicare Advantage plan payments for 2011 are frozen at 2010 levels. Beginning in 2012, payments will have a county-based pricing structure and will be phased down to benchmark targets based on fee-for-service (FFS) costs.
- *Quality bonus.* Beginning in 2012, MA plans will be eligible for a quality bonus incentive payment based on the Centers for Medicare and Medicaid (CMS) Five-Star Rating System, to be phased in over three years.
- *Quality rebates.* Currently plans that bid below the benchmark receive a rebate of 75 percent of the difference, which must be used for additional benefits or reduced cost-sharing by beneficiaries. These rebates are being reduced over the next three years.
- *Coding intensity adjustment.* This provision requires CMS to annually perform analysis of MA/FFS coding pattern differences and incorporate results into risk scores on a timely basis.
- *Risk-adjustment methodology.* For 2011 and periodically thereafter, the HHS secretary must evaluate and revise the risk-adjustment methodology to accurately account for costs associated with frailty and chronic conditions.

- *MA cost-sharing.* This provision prohibits MA plan cost-sharing greater than FFS Medicare for chemotherapy treatment, renal dialysis and skilled-nursing care beginning in 2011.
- *Denial of MA and Part D bids.* This provision gives the HHS secretary the authority to deny MA or PDP plan bids that propose significant increases in cost-sharing or decreases in benefits.
- *Medical loss ratios (MLRs).* Beginning in 2014, MA plans are required to achieve at least an 85 percent MLR for a contract year or pay a penalty. Further penalties will apply if a plan fails to achieve the required ratio over a period of consecutive years.
- *Enrollment periods.* Effective in 2011, the Annual Election Period (AEP) moves from November 15 through December 31 to October 15 through December 7. The MA Open Enrollment Period (OEP) traditionally held between January 1 and March 31 has been eliminated. Also beginning in 2011, during a 45-day period from January 1 through February 14, beneficiaries enrolled in MA or MA Part D plans may disenroll to traditional fee-for-service Medicare and choose a stand-alone Part D plan.
- *Special needs plans (SNPs).* SNPs have been reauthorized through 2013. State contracting for dual-eligible SNPs is not required through 2012. Dual-eligible SNPs without state contracts cannot expand service areas. Beginning in 2012, the National Committee for Quality Assurance (NCQA) must approve SNP plans.
- *The Part D coverage gap (the doughnut hole).* In 2010, CMS will make a $250 payment to non-LIS (low-income subsidy) beneficiaries who have exceeded the initial coverage limit. Beginning in 2011, a coverage gap discount program will require drug manufacturers to provide a 50 percent discount to enrollees in the coverage gap at the point-of-sale in order to participate in Part D. Under the standard drug benefit, cost-sharing for generic and brand drugs will also phase down for non-LIS beneficiaries through 2020.

[*Please note:* There are no immediate (2010) changes to Medicare. Requirements for 2011 are addressed in Health Net's bid submission and pricing, and are occurring through Medicare's existing work flow.]

GENERAL QUESTIONS ABOUT MEDICAID AND CHIP

Q. What is the impact of reform legislation on Medicaid and CHIP?

A. The following reforms will impact Medicaid and the Children's Health Insurance Program (CHIP):

- *Eligibility and benefits.* The new law creates four new mandatory eligibility categories for those who are at or below 133 percent of the federal poverty level, with optional expansion to non-elderly, non-pregnant individuals. From 2014 through 2016, the federal government will pay 100 percent of the cost of covering the newly eligible. The law also defines several new mandatory benefits.
- *Federal Medical Assistance Percentage (FMAP) for expansion populations.* Beginning in 2017, the law incrementally decreases the federal medical assistance percentage (FMAP) for covering the newly eligible, resulting in a rate of 90 percent by 2020 and each year thereafter.
- *Premium assistance and wraparound benefits.* Beginning in 2014, states will be required to offer premium assistance and wraparound benefits to Medicaid beneficiaries who are offered employer-sponsored insurance. The law also facilitates enrollment coordination with state Exchanges and requires states to establish a website to promote seamless enrollment in Medicaid, CHIP or the Exchange.
- *Prescription drug rebate.* The new law increases the brand-name and generic drug Medicaid rebate amounts and requires that the federal government receive 100 percent of the additional dollars attributable to the rebate increase.
- *The Children's Health Insurance Program.* CHIP has been reauthorized through September 30, 2015. Beginning in 2014, states must establish Health Benefit Exchange procedures for enrolling individuals in Medicaid and CHIP.