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Answers to 7 pressing health-care questions

New rules coming as first changes from health reform kick in

By [Kristen Gerencher](#), MarketWatch

SAN FRANCISCO (MarketWatch) — Parents who want to add their adult children to their health plans and people concerned they'll burn through low annual limits on their health benefits if they get sick are about to get some relief as the health-reform provisions kick in.

Many of the changes are meant as a bridge until 2014, when for the first time health plans will be available, with subsidies for those who can't afford it, in a new insurance marketplace; most individuals will have to have coverage or face a financial penalty; and insurers won't be able to reject applicants who already have health conditions.

"We're at the beginning of a new era for the health-insurance marketplace," said Steven Findlay, senior health policy analyst for Consumers Union in Washington.

The first wave of the health overhaul's significant changes takes effect for most health plans Sept. 23, six months after President Obama signed the bill into law. But many Americans won't be able to reap the benefits until January at the earliest because the law applies to new health plans begun on or after Sept. 23.

"If you already have insurance, which is the bulk of people, then you won't feel it until the new plan year starts," said Dr. Kavita Patel, director of the health policy program for the New America Foundation in Washington.

Here are answers to seven common questions, based on interviews with health-policy experts.

1. What is a grandfathered health plan?

Some employers and insurers may make only minor changes to their health plans so they don't have to comply with all the new regulations right away. These are so-called grandfathered plans, and every year the law makes it harder to be one. Employers and insurers are supposed to disclose in writing if their health plans have grandfathered status. If you're unsure whether your health plan is adopting the new rules, ask if it has grandfathered status.

2. What new benefits apply to both grandfathered and new health plans?

There are three major new benefits that apply to both kinds of plans, Findlay said. Health plans that place lifetime dollar limits on the benefits they potentially pay out on behalf of a member will no longer be able to impose such limits. Right now, those lifetime limits can be low in some industries and types of coverage.

All health plans also will be banned from excluding children under age 19 because they have preexisting health conditions. And they can't retroactively cancel your coverage if you get sick, a practice known as rescission that became a problem in the individual health-insurance market.

3. Are annual benefit limits still allowed?

Yes, but the thresholds get higher each year before they completely disappear in 2014. For new group health plans, the minimum annual limit on how much a health plan has to pay out in benefits rises to \$750,000, but cash-strapped small employers can apply for a waiver, said Stephen Finan, senior director of policy for American Cancer Society's Cancer Action Network in Washington.

"In the individual market, grandfathered plans don't have to comply with the \$750,000 [limit] but new plans do," he said. "It's not clear to us how that waiver provision is going to work in practice. Many of the minimed [limited-benefit plans] have annual limits substantially below that. We've seen as low as a few thousand dollars."

While some seriously ill patients still may find the \$750,000 annual limit a hardship, Finan said, this policy change, if applied broadly, would meet many cancer patients' needs.

The effect of the new rule will be to root out "junk insurance" plans from the market, Findlay said.

4. What's changing with preventive care?

For new health plans, preventive-health services that have proven effective with a grade of "A" or "B" from the U.S. Preventive Services Task Force will be available to consumers without cost-sharing, making them effectively free to the patient. That includes routine immunizations and screenings such as those for breast, colon and cervical cancer.

Smoking cessation is also covered, but it's unclear how many counseling sessions would be free of cost-sharing, Finan said. Plus, since the task force makes recommendations for people at average risk of diseases, those deemed high risk still may have to pay a copay for screenings their doctor prescribes, he said.

Questions remain about how patients can claim the benefit in some cases. But the change will help people who forego routine screenings because of out-of-pocket costs, Finan said.

"Even small copays can discourage as many as 10% to 20% of people from getting the services," he said.

For people over 50, for example, the new rule could tip the scale in favor of receiving a recommended colonoscopy. Depending on geography, the procedure can cost more than \$1,000, leaving patients with coinsurance on the hook for a big portion of the total tab.

Many large employers already offer first-dollar coverage for some preventive services, but the new rule typically will require a more extensive list for employers that don't have grandfathered status, said Michael Thompson, principal in PWC's human-resource services practice in New York.

5. Can I add my adult kids to my health plan?

In most cases, parents will be able to add or keep their adult children on their health plans until those children turn 26, regardless of their educational, marital or dependent status, and health plans can't charge more for them than other dependents.

"Most employers today only cover children to age 23 if they're in school or 19 if they're not in school," Thompson said. "It's a pretty substantial increase in coverage."

6. Will I have any more recourse if I need to fight an insurer's decision on a claim?

Yes. New health plans will have to open up a second level of appeal through an external third party, Thompson said.

"Today health plans and employers have an appeal process they manage if they have someone who feels their claim was wrongfully denied," he said. New plans

will have to have an external appeal process that would potentially override the first-level internal decision.

7. Will my health-plan costs rise because of the new benefit requirements?

That depends. A recent survey of large employers from the National Business Group on Health suggested the new rules related to health reform will add about 1% to the cost growth projected for their 2011 health plans. Many employers are scouring their plan designs for ways around cost problems.

“Because almost all of the reforms that hit early are in the form of benefit mandates, establishing minimum standards for benefits, this will raise cost for employers who do this and nothing else,” Thompson said. “Most employers are looking to keep their costs even or mitigate their cost increases by implementing other changes at the same time.”

It appears that was already happening before health reform became the law of the land. Thirty-eight percent of large companies said they reduced the scope of their benefits or increased workers’ cost-sharing in their 2010 health-benefit offerings, up from 22% who did so in 2009, according to a survey released earlier this month from the Kaiser Family Foundation.

What’s more, 36% said they increased workers’ share of the premium this year, up from 22% who passed on a bigger share of the premium last year