

CONTACT US

Are you on the Penn-Ohio e-mail list?
Please send your updated e-mail address
to: tfinneran@tjsins.com.

If you have a question, comment, or
suggestion you want to share with
HealthAssurance and/or Penn-Ohio; or
if you have a particular HealthAssurance
experience you would like to
share with other Penn-Ohio
members, let us know:

E-mail to:

jwall@cvty.com

Fax to:

1-866-341-0413

Mail to:

Jerry Wall

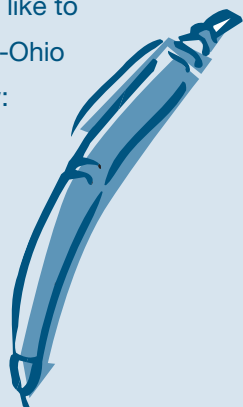
Director of Sales,

Western Pennsylvania

HealthAmerica/HealthAssurance

11 Stanwix Street • Suite 2300

Pittsburgh, PA 15222



Services, continued from page 11

Reimbursement for Health Education

When you take an approved health education class, HealthAmerica will reimburse you for some—and most times all—of the cost.* Approved classes include smoking cessation, weight management, diabetes education, nutrition and general wellness. You can even learn about safety, including CPR, first aid, and infant and child safety. Most courses are offered at area hospitals or health care providers.

There is no limit to the number of classes you can take, and no diagnosis or condition is required to be eligible for the reimbursement program. Visit the wellness resources section of our website to learn more about the rules and limitations of the program and to find a list of classes in your area.

If you don't have Internet access, call Customer Service.

*Check with your group administrator to see if your group offers this benefit. Weight management classes are limited to \$150 reimbursement per member per year.

Get Health Answers 24/7

1-866-491-4462. You can call HealthAmerica's NurseLine toll-free, 24 hours a day, seven days a week, including holidays. A registered nurse will help you any time you are sick, injured or have a health care question. You will get immediate answers and help in making the best health care decisions for yourself. Nurses can help you even if you don't speak English. The NurseLine offers translation services in more than 140 languages.

Pennsylvania in-area PPO and CCPPO (POS) products are underwritten by HealthAssurance Pennsylvania, Inc. (d.b.a. HealthAmerica). All out-of-area PPO products, HealthAmerica One products, and Ohio in-area PPO products are underwritten by Coventry Health and Life Insurance Company (d.b.a. HealthAmerica).





**Educational Meeting:
May 20th**

See page 8 for more details

2nd Quarter 2010 Spring Issue

Board of Directors

Mark Tomaszewski
President
INMETCO

Karen E. Biscella
Vice President

Christy Pease
Secretary/Treasurer
Heritage-WTI, Inc.

Dr. Larry Baling
*Sharon Regional
Health Systems*

Alice Nunes
*Butler County
Children's Center*

Paul "Rusty" Rader
J.J. Kennedy, Inc.

Mark Pappa
Brighton Hot Dog Shoppes

J. Timothy Faller
Executive Director
*Tucker, Johnston &
Smelzer, Inc.*

Tom Finneran
Employee Benefits
Consultant
*Tucker, Johnston &
Smelzer, Inc.*

Letter from the Board of Penn Ohio

As we usher out a cold and snowy winter, I'd like to thank all of our long standing members, as well as those new employers that joined the Penn-Ohio in 2009 for their support. We again had a successful year with 418 employers taking advantage of the purchasing power this group provides: an increase of over 78 employers and close to 2,000 new employees from the prior year.

With a new contract January 1, 2010, with HealthAmerica, members receive a rate 3 percent lower than what is available to non-members in the Penn-Ohio service area. The contract also extends the service area of the Penn-Ohio to Armstrong County. With this addition, we now serve Armstrong, Beaver, Butler, Lawrence, and Mercer Counties in Pennsylvania, and Columbia, Mahoning and Trumbull Counties in Ohio.

Health Care Reform

As you are all well aware, a monumental piece of legislation was introduced, The Patient Protection and Affordable Care Act (PPACA), which will dramatically change the health care landscape in this country. While we don't feel the bill contains anything to address rising costs, this is what we've been dealt.

While many of the reforms in the bill will be phased in over the next eight to 10 years, there are some you'll need to be aware of immediately for 2010.

New Plans and Coverage

- A temporary retiree reinsurance pool
- A national high risk pool is created
- A small business tax credit for employer less than 25 employees is established
- \$250 rebate for Medicare members reaching the "doughnut hole"

Reform

- Prohibits lifetime benefit maximums
- Coverage rescissions or calculations are prohibited
- Cost-sharing objections for preventive benefits is prohibited
- Dependent coverage up to age 26 is mandated
- Pre-existing condition exclusions for dependent children under age 18 are prohibited

Letter, continued on page 2

In This Issue

2 Health Reform
and the Group
Commercial Market

8 Using the Emergency
Room Wisely
Educational
Meeting – May 20th

9 Why You Shouldn't
Take Antibiotics
Childhood
Immunizations are
More Important
Than Ever

10 Men's Health:
Be a Wise Guy

11 Pantry Pointers
Services to Support
Your Health

Published by
HealthAmerica
11 Stanwix Street
Suite 2300
Pittsburgh, PA 15222
412-553-7500
Fax 412-553-7386
www.healthamerica.cvty.com

Letter from the Board of Penn Ohio continued from page 1

Also, included in this newsletter is a detailed timeline that has been prepared by Coventry Health Care, “Health Reform and the Group Commercial Market,” outlining the changes that employers and insurers will be subject to over the coming years.

Annual Meeting

The Penn-Ohio annual meeting was held February 18th and was one of the most well attended meetings in recent years. The meeting was held at the Avalon Golf and Country Club and over 45 members attended.

Alvin Harper of the Hospital Council of Western Pennsylvania presented the hospital’s perspective on health care reform. Mr. Harper gave examples of reimbursement levels provided to hospitals across the state citing a few examples of procedure, and the negative impact PPACA will have on hospitals’ revenue in the region.

Again thank you for your continued support of the Penn Ohio Regional Health Care Alliance.

Health Reform and the Group Commercial Market

In March 2010, President Obama signed landmark new health reform legislation into law. This new law has two pieces—the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010 (“Health Reform Acts”). When joined together, these pieces will result in major changes across the U.S. health care system for virtually everyone, but especially health insurers and the customers who rely on our products to deliver both high-quality health care and financial security at an affordable cost.

Specifically, the Health Reform Acts will lead to **important changes in the group commercial market** for large and small employers in the coming months and years. This document provides an overview of many of the biggest changes to the group commercial market along with the effective date. However, it is important to remember that the specific details of how the changes will be implemented are subject to new regulations from the U.S. Department of Health & Human Services (HHS), National Association of Insurance Commissioners (NAIC), or other authorized entity.

Changes Effective in 2010

Issue	Summary	Effective Date
Grandfather Plan Status	<ul style="list-style-type: none"> • Extends “grandfather status” to existing group health insurance plans in effect on the date of enactment • Specifies that nothing in the new law requires an individual to terminate their existing coverage • Authorizes new employees and family members to join grandfathered plans if permitted under the terms of the plan 	Upon enactment (Mar 23, 2010)
Small Business Tax Credit	<ul style="list-style-type: none"> • Provides a new sliding-scale tax credit to employers with less than 25 employees and average annual wages below \$50,000 to offset the cost of health coverage if they contribute at least 50% of the total premium cost 	2010 tax year
Medical Loss Ratio (MLR) Reporting	<ul style="list-style-type: none"> • Requires health insurers offering group coverage to report MLRs to the HHS Secretary for each plan year that will be publicly posted on the Internet • Excludes self-insured group health plans from requirement • Implementation subject to HHS regulations issued with the NAIC 	Upon enactment and applies to 2010 plan year

Pantry Pointers

How to stock your kitchen with healthy options

If you want to eat better, you need to shop better. By keeping some smart choices on hand, you'll be ready to whip up a healthy meal or snack anytime.

The American Dietetic Association suggests always having beans, brown rice, pasta, oatmeal and barley in the pantry. Try using brown rice and barley to stretch and add fiber to stews, soups and casseroles. Beans are an excellent source of protein and give a tasty touch to salads and other dishes. They're also yummy on their own, warmed up with your favorite seasonings.

It's a good idea to have some canned fish, like salmon or tuna, in the house, too. Both are a great source of omega-3 fatty acids and protein, and can be used in a variety of recipes.

Dried fruits, tomatoes and mushrooms store well and can add flavor and nutrition to rice or grain dishes. And don't turn your nose up at canned fruits and vegetables, especially during fall and winter when some foods aren't in season. Just look for fruit packed in fruit juice instead of syrup. Choose low-sodium veggies if you're watching your salt intake.

Nuts are another great item to have in the pantry, as a heart-healthy snack or addition to dishes ranging from salads to main courses. Try coating chicken or fish in chopped nuts instead of bread crumbs.

When you're grocery shopping, always check out what's on sale and stock up on basics, such as low-sodium canned soup and broth, low-fat salad dressing, condiments and frozen vegetables. They all have long shelf lives, so buy now and save later.

Another way to stock up on healthy food is to make extra portions of whatever you're cooking and freeze them. Freezing some of it to enjoy later is healthier and less expensive than a pre-packaged frozen dinner.

And when you're heading to the store, be sure to take a list. You'll be more likely to buy the healthy items you set out to get in the first place, and less likely to be distracted by the tasty but not-so-good-for-you treats you're trying to avoid.

Services to Support Your Health

Health education coaches provide invaluable support to members with asthma, diabetes, COPD, coronary artery disease and congestive heart failure.

When you're battling a chronic illness, it helps to have someone in your corner who knows about the disease, the treatment options and ways to maintain a healthy lifestyle. That's the job of our health education coaches.

Through occasional telephone calls and mailings, health education coaches will help you with self-management of chronic conditions and developing goals. They even help obtain supplies, find resources and connect with our health education programs. If you're battling a chronic illness, you're not alone. HealthAmerica's health education coaches are in your corner to help you live a winning lifestyle.

We Can Help

To speak to one of our health education coaches about asthma, diabetes, coronary artery disease, congestive heart failure or COPD, call (866) 777-7150.

Services, continued on page 12





Men's Health: Be a Wise Guy

There are times when your body will tell you something's wrong, like when you twist your ankle playing basketball and it swells and starts to hurt. But there are other health conditions your body isn't going to tell you about, such as high cholesterol or high blood pressure, neither of which causes symptoms.

That's where routine testing comes in. Every man should have certain screenings on a regular basis. Here are the basic recommendations for most men, but be sure to talk to your doctor about when and how often you should have your routine screenings.

At your general checkup (usually once a year) you need:

A blood pressure test. At least every two years, to monitor your risk of heart disease.

A cholesterol test. Regularly starting at age 35, or sooner if you have other health issues such as diabetes or high blood pressure that can increase your risk of heart disease.

A blood glucose (A1c) test. Starting at age 45, or earlier if you have risk factors for or a family history of diabetes.

A body mass index (BMI) measurement. Regularly screen for obesity by calculating your BMI, which is a measure of body fat based on height and weight; your doctor can check BMI or you can find calculators online.

Colorectal cancer screening. Starting at age 50, or earlier if you have risk factors or a family history. There are a number of available tests. Ask your doctor which one is right for you, such as a colonoscopy, which should be performed every 10 years, or a fecal occult blood test, which needs to be done every year.

A testicular exam. Perform a monthly self-exam and have your doctor perform one as part of your general check-up, to test for testicular cancer. Feel for any lumps or bumps.

An abdominal aortic aneurysm test. Once between the ages of 65 and 75, if you have ever smoked (100 or more cigarettes in your lifetime), to check for an abnormally large or swollen blood vessel in your abdomen.

No Jokin' Around: See Your Doctor

Men are less likely than women to visit the doctor and use medical services, even if they're experiencing symptoms of something as serious as a heart attack. In fact, a recent U.S. Census Bureau report showed that almost one-third of men said they had not seen a doctor in the previous 12 months.

But men need to look after their health the same way women do—especially when you consider that one in five American men has heart disease and three in four are overweight, according to the Agency for Healthcare Research and Quality.

It's important to see your doctor regularly. Be sure to give your doctor as much information as you can about your health history, the medicines you're taking and any problems you might be having. It's the best way for your doctor to determine how to help you stay healthy.

Visiting the doctor isn't a sign of weakness—it's actually a show of strength. If you want to take care of your loved ones for years to come, start by taking the best possible care of yourself.

Health Reform, continued from page 2

Changes Effective in 2010		
Issue	Summary	Effective Date
Premium Review Process	<ul style="list-style-type: none"> Requires the HHS Secretary in conjunction with States to establish a process for the annual review of changes in insurance premiums Requires plan justification for any increase and disclosure on the plan's public website Directs States to make recommendations to the State Health Exchange (not until 2014 and after) on whether particular insurers should be excluded based on a "pattern or practice of excessive or unjustified premium increases" 	Upon enactment and applies to 2010 plan year
Reinsurance for Early Retirees	<ul style="list-style-type: none"> Directs the HHS Secretary to establish temporary \$5 billion (capped) reinsurance program until Jan 1, 2014 to offsets a portion of the costs of providing health insurance to early retirees (and their dependents) Requires the HHS Secretary to reimburse participating employer plans for 80% of an early retiree's health costs above \$15,000 but less than \$90,000 Requires reinsurance payments to be used by employers to reduce premium costs, premium contributions, co-pays, deductibles, or other out-of-pocket costs for plan participants 	No later than Jun 23, 2010
Children with Preexisting Conditions	<ul style="list-style-type: none"> Prohibits health insurers offering group coverage from imposing any preexisting condition exclusion with respect to plan coverage for enrollees under age 19 Applies to a child's access to a plan and benefits after enrollment (HHS Secretary clarification) 	Effective plan years starting on or after 6 months after enactment (Sep 23, 2010)
Dependent Coverage to Age 26	<ul style="list-style-type: none"> Requires health insurers offering group coverage that provides dependent coverage of children to cover an adult child until age 26 	Effective plan years starting on or after Sep 23, 2010
Annual or Lifetime Limits	<ul style="list-style-type: none"> Prohibits health insurers offering group coverage from establishing lifetime or annual limits on the dollar value of benefits Allows for annual limits on "essential health benefits" as defined by the HHS Secretary prior to 2014 	Effective plan years starting on or after Sep 23, 2010
Rescissions	<ul style="list-style-type: none"> Prohibits health insurers offering group health insurance from rescinding the plan or coverage once an enrollee is covered except in instances of intentional misrepresentation of material fact 	Effective plan years starting on or after Sep 23, 2010
Appeals Process	<ul style="list-style-type: none"> Requires health insurers offering group coverage to implement an effective appeals process for appeals of coverage determinations and claims Requires process to include an internal claims appeal process, providing notice to enrollees in a culturally and linguistically appropriate manner and informing enrollees of any applicable consumer assistance, and allowing enrollees to review their file 	Effective plan years starting on or after Sep 23, 2010

Changes Effective in 2010		
Issue	Summary	Effective Date
Coverage of Preventive Health Services	<ul style="list-style-type: none"> Requires health insurers offering group coverage to cover any preventive services rated A or B by the US Preventive Services Task Force, Advisory Committee on Immunization Practices (ACIP) recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women at \$0 co-pay 	Effective plan years starting on or after Sep 23, 2010
Highly Compensated Individuals	<ul style="list-style-type: none"> Prohibits group health plans from providing benefits that favor highly-compensated individuals (as defined by the Internal Revenue Code) or limiting coverage eligibility based on employee salary 	Effective plan years starting on or after Sep 23, 2010
Grand-fathered Plan Rules	<ul style="list-style-type: none"> Requires dependent coverage to age 26 Prohibits rescissions Prohibits lifetime limits Eliminates waiting periods for coverage over 90 days 	Effective plan years starting on or after Sep 23, 2010

Changes Effective in 2011		
Issue	Summary	Effective Date
Minimum MLR	<ul style="list-style-type: none"> Requires health insurers offering group coverage to attain an 85% MLR for large groups and 80% MLR for small groups (or higher if required under state law) for each plan year Requires the plan to provide rebates to each enrollee on pro rated basis if the annual MLR targets are not met Directs NAIC to establish uniform definitions and standardized methodologies to comply with requirements by Dec 31, 2010 Implementation subject to HHS and NAIC regulations 	No later than Jan 1, 2011
Large & Small Group Definitions	<ul style="list-style-type: none"> Defines large group as a group health plan in connection with an employer with an average of at least 101 employees Defines small group as a group health plan in connection with an employer with an average of 1 to 100 employees Authorizes States to define large group as over 50 employees and small group as under 50 employees until January 2016 	Jan 1, 2011
Value of Health Benefits	<ul style="list-style-type: none"> Requires employers to report the aggregate cost of employer-sponsored health coverage on employee W-2 forms 	Jan 1, 2011
FSA, HRA, HSA Changes	<ul style="list-style-type: none"> Prohibits distributions from flexible spending accounts (FSAs), health reimbursement accounts (HRAs), and health savings accounts (HSAs) for over-the-counter drugs and other non-prescription products unless prescribed by a physician 	Jan 1, 2011

Why You Shouldn't Take Antibiotics

Antibiotics have long been thought of as wonder drugs that can cure illness and even save lives. But today, not taking an antibiotic could actually save your life—or the life of someone you love—in the future.

That's because as powerful as antibiotics are, the bacteria that they fight are strong too. When you use an antibiotic for the wrong kind of illness or you don't take it correctly, the bacteria that cause infections can become resistant to the drugs that once killed them. That puts you and anyone else who becomes infected with these now-resistant bacteria at risk of serious and potentially deadly illness.

It is up to every one of us to help antibiotics stay powerful. Here's how:

- 1. Know when antibiotics can help and when they can't.** Only bacterial infections can be treated with antibiotics. Antibiotics do nothing for illnesses caused by a virus, like colds, the flu, and most coughs and sore throats. Don't pressure your doctors for antibiotics: Let them decide whether the drug is right for your condition.
- 2. Take your medicine exactly as the doctor tells you.** If your doctor does give you an antibiotic, ask how and when to take it. Don't stop taking it even if you feel better. Finish the entire prescription. If you don't, the strongest bacteria can be left to continue your infection.

Childhood Immunizations are More Important than Ever

According to the Centers for Disease Control and Prevention, the number of children in the U.S. receiving immunizations is at an all-time high. There have been major increases in the number of people getting varicella (chickenpox) and pneumococcal conjugate vaccine. These are two of the most recent additions to the recommended immunization schedule.

It's no coincidence that we also have record, or near-record, low levels of the kind of childhood diseases that can be prevented by vaccine. But make no mistake, these diseases have not disappeared. The viruses and bacteria that cause them are still alive, circulating in this country, or just a short plane ride away in countries where vaccination is not so widespread.

That's why it's important—very important—that children, especially infants and young children, receive recommended immunizations on time. A major study from the Institutes of Medicine put to rest a number of unfounded rumors about childhood vaccination. Parents who have been needlessly frightened by tales of vaccination-related illnesses should be breathing easier. If your children have missed any in their series of vaccinations, or are ready for the next phase, contact your physician and get them protected.

Recommended Childhood Immunization Schedule*

Birth to 2 Months	Hepatitis B, first dose
2 Months	Polio; Diphtheria, tetanus, acellular pertussis (DTaP); Haemophilus (Hib); Pneumococcal (PCV); Rotavirus (RV), first dose
1 to 4 Months	Hepatitis B, second dose
4 Months	Polio; DTaP; Haemophilus (Hib); PCV; Rotavirus (RV), second dose
6 Months	DTaP; Haemophilus (Hib); PCV; Rotavirus (RV), third dose
6 to 18 Months	Polio; Hepatitis B, third dose
6 Months to 18 Years	Influenza (annually)
12 to 15 Months	Varicella (chickenpox); Measles, mumps, rubella (MMR), first dose; Haemophilus (Hib); PCV
12 to 23 Months	Hepatitis A, two doses
15 to 18 Months	DTaP
2 to 18 Years	Hepatitis B series; varicella (all only if not previously given)
4 to 6 Years	Polio; DTaP; MMR, second dose; varicella, second dose
11 to 12 Years	HPV, three doses; Meningococcal (MCV); Diphtheria, tetanus (Td); MMR (if not given at 4 to 6 years)

*Are you covered? Check with your health plan administrator to see what services are covered under your specific policy.

Using the Emergency Room Wisely

Save time and money by knowing where to go for treatment

What is an Emergency?

HealthAmerica defines a medical emergency as a **sudden accident or sudden medical condition that causes severe symptoms or severe pain**. You could reasonably expect that if you did not receive immediate medical attention in a medical emergency, it would:

- Place your health in serious jeopardy.
- If you are pregnant, place the health of your fetus in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any bodily organ or part.

If you have a medical problem that is not a true emergency, be sure to call your PCP or doctor first. He, she or an on-call partner is available 24 hours a day and knows you, your medical history and the best place to go for your care.

A true medical emergency presents an immediate danger. Some examples might include, but are not limited to:

- Poisoning or drug overdose
- Difficulty breathing or shortness of breath
- Chest or upper abdominal pain or pressure

- Fainting, sudden dizziness, weakness, loss of consciousness
- Changes in vision
- Confusion or changes in mental status
- Uncontrolled bleeding
- Coughing or vomiting blood
- Suicidal feelings
- Difficulty speaking
- Severe pain

PCP—Your primary care physician and his or her associates are best prepared to advise you about when and where to seek urgent care.

True medical emergencies do not need prior authorization. If you believe that you or your family member should be treated right away, call 911 or your local emergency number, or go directly to the nearest ER.

Your Coverage

If you go to an emergency room for a condition that is not an emergency, the charges may not be covered. Emergencies treated in the ER are covered in full by HealthAmerica. If you are treated for an emergency and released, you will generally need to pay a copayment to the hospital. Copayments are waived if you are admitted to the hospital.

Follow Up With Your Doctor

Always call your doctor as soon as possible after you are treated or admitted to a hospital. This will ensure that if you need follow-up care, such as the removal of stitches, you're covered at the highest level. It will also ensure that your medical records are kept current.

Educational Meeting – May 20th

The Penn-Ohio Regional Health Care Alliance cordially invites their member companies to attend the spring educational session. **Mr. Kurt Crytzer**, an accountant with the CPA firm of Malin Bergquist and Company, will discuss the Small Business Health Care Tax Credit. The meeting will be held **Thursday, May 20, 2010, at 12:00 pm** at the **Avalon Country Club in Hermitage, PA.**

Changes Effective in 2012 and later

Issue	Summary	Effective Date
Information Standards	<ul style="list-style-type: none"> • Requires the HHS Secretary to develop standards with the NAIC on summary of benefits and coverage explanations within 12 months after enactment (effective 1 year later) • Requires plans to provide standardized information to applicants, enrollees, and policyholders in paper or electronic format • Preempts any related State standards 	Effective no later than 24 months after enactment (Mar 23, 2012)
Quality Reporting	<ul style="list-style-type: none"> • Requires development by HHS of standardized annual quality reporting requirements by group health plans • Requires reports to address plan coverage benefits and health care provider reimbursement structures that improve health outcomes and patient safety, prevent hospital readmissions, and implement wellness and health promotion 	By Mar 23, 2012
FSA Limits	<ul style="list-style-type: none"> • Imposes a \$2,500 limit on employee contributions to health FSAs with adjustments for inflation in future years (does not include employer contributions) 	Jan 1, 2013
Electronic Health Transactions	<ul style="list-style-type: none"> • Directs the HHS Secretary to adopt a single set of operating rules for electronic health transactions (e.g., eligibility verification, claims status) by July 1, 2011 • Requires health plans to certify to HHS that data and information systems are in compliance with standards and operating rules for electronic funds transfers, health plan eligibility, health claim status, and health care payment and remittance advice 	Dec 31, 2013
Employer Mandate	<ul style="list-style-type: none"> • Requires employers with more than 50 employees that do not offer coverage and/or have employees who receive a government subsidy to purchase insurance through the Exchange to pay financial penalties <ul style="list-style-type: none"> – \$2,000 penalty per full-time employee for employers that do not offer coverage – The lesser of \$3,000 for each employee receiving a tax credit or \$2,000 per full-time employee for employers that offer coverage – Excludes first 30 employees from penalty calculation • Requires employers with 200 employees or more to auto-enroll them in employer coverage unless the employee opts out and shows proof of other coverage • Requires employers that offer health coverage and make contributions to its cost to provide a voucher equal to the health insurance premium contribution for those employees with income below 400% of federal poverty level (FPL) and coverage contribution requirements between 8.0-9.8% of income so they may instead purchase coverage through the Exchange <ul style="list-style-type: none"> – 400% FPL (2009) = \$43,320/individual and \$88,200/family of 4 	Jan 1, 2014

Changes Effective in 2012 and later		
Issue	Summary	Effective Date
Health Exchanges	<ul style="list-style-type: none"> Establishes State-based American Health Benefit Exchanges through which individuals can buy health insurance Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange with at least one plan offered by a non-profit entity Creates four benefit-categories of plans—Bronze, Silver, Gold, Platinum—plus a Catastrophic Plan available to those under age 30 Requires all plans (inside and outside the Exchange except grandfathered plans) to cover “essential health benefits” 	Jan 1, 2014
Health Benefit Standards	<ul style="list-style-type: none"> Essential Health Benefits include: ambulatory patient services, emergency room services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services Caps out-of-pocket costs equal to the limits under HSAs (\$5,950/individual and \$11,900 family in 2010) Restricts deductibles for small group plans to \$2,000 for individuals and \$4,000 for families 	Jan 1, 2014
Small Group Participation in Exchanges	<ul style="list-style-type: none"> Directs States to create a Small Business Health Options Program (SHOP Exchange) to assist small employers in facilitating enrollment in qualified health plans Allows small businesses with up to 100 employees to purchase coverage through the SHOP Exchange 	July 1, 2014
Subsidies for Individuals	<ul style="list-style-type: none"> Provides individuals with incomes between 133% to 400% FPL with sliding-scale, advanceable premium and cost sharing credits to buy insurance through the Exchanges 	Jan 1, 2014
Insurance Market Rules	<ul style="list-style-type: none"> Imposes many new insurance rules on group health plans in conjunction with start of the Exchanges: <ul style="list-style-type: none"> Guaranteed issue and renewability Rating variation for small group plans based only on age (3:1), premium rating area (at least 1 per state), family composition, and tobacco use (1.5:1). Excludes self-insured group from rating requirements. Prohibits the use of health status, medical condition, medical history, etc. in establishing eligibility No annual lifetime limits on dollar value of coverage No rescissions except in cases of fraud No exclusions for preexisting conditions 	Jan 1, 2014

Changes Effective in 2012 and later

Issue	Summary	Effective Date
Health Insurer Premium Taxes	<ul style="list-style-type: none"> • Imposes a new \$8 billion tax on health insurers starting in 2014 that rises to \$14.3 billion in 2018 • Levies the tax based on plan net premiums as percentage of total US net premiums <ul style="list-style-type: none"> – Excludes 50% of net premiums for non-profit plans – Exempts non-profit plans that receive 80% or more of their revenue from Social Security Act programs that target low-income, elderly, or disabled individuals – Exempts administrative-services only (ASO) fees for self-insured employers and self-insured employer plans – Exempts long-term care insurance and Medigap plans – Exempts voluntary employee benefit associations – Exempts governmental entities 	Jan 1, 2014
Risk Pools	<ul style="list-style-type: none"> • Requires health insurers to consider all enrollees in all health plans offered in the small group market in a State (other than grandfathered health plans) to be a single risk pool • Authorizes States to require insurers to merge the individual and small group insurance markets within a State 	Jan 1, 2014
Risk Corridors	<ul style="list-style-type: none"> • Establishes risk corridor program for qualified health plans in the small group market for 2014-2016 • Provides government payments to plans if total allowable costs exceed 103% of the target amount. Payments equal: <ul style="list-style-type: none"> – 50% of costs above 103% but less than 108% of target – 80% of costs above 108% of target • Requires plan payments to the government if total allowable costs are below 97% of the target amount. Payments equal: <ul style="list-style-type: none"> – 50% of costs below 97% but above 92% of target – 2.5% of target plus 80% of costs below 92% of target 	Jan 1, 2014
Independent Payment Advisory Board	<ul style="list-style-type: none"> • Creates the Independent Payment Advisory Board • Directs the Board to submit recommendations to Congress to slow growth in national health expenditures (and recommendations to reduce Medicare spending one year earlier) 	Submit proposal by Jan 15, 2015
Health Care Choice Compacts	<ul style="list-style-type: none"> • Permits States to form health care choice compacts and allow insurers to sell policies in any State participating in the compact 	Not before Jan 1, 2016
Large Groups in Exchange	<ul style="list-style-type: none"> • Authorizes States to allow employers with more than 100 employees into the State Exchange 	Jan 1, 2017
Cadillac Plan Tax	<ul style="list-style-type: none"> • Imposes a 40% excise tax on “Cadillac” health plans when the value of coverage exceeds \$10,200 for individual and \$27,500 for families 	2018 Plan Year