LEGISLATIVE COUNSEL MEETING
HEALTH CARE REFORM

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Fact Sheet on Establishing the Web Portal Called For in The Affordable Care Act

Background

One of the most important goals for the Affordable Care Act is to give Americans more control over their own health care and ensure all Americans have the information they need to make the choices that are best for them, The Administration has been working hard since the Affordable Care Act was enacted on March 23, 2010 to meet the deadlines set out in the legislation.

In addition to giving all Americans access to affordable insurance beginning in 2014 and taking interim steps within the year to make insurance more available to those with the greatest need for coverage, the Affordable Care Act also includes a provision to make it easier to get information about available health insurance options now. This provision establishes an internet portal to help individuals and small businesses identify insurance options in their state.

The web portal will help consumers navigate their options in the individual and small business private market and help them determine if they may be eligible for a variety of existing public programs, including existing state high risk pools, new high risk pools, Medicaid, Medicare and the Children's Health Insurance Program (CHIP).

In addition to information on health insurance options, the new web portal will provide information on the small business tax credits available for 2010 and beyond. It will also provide information on the Early Retiree Reinsurance Program including instructions on how businesses that provide coverage to non-Medicare retirees age 55 and older can enroll to receive reinsurance payments to stabilize coverage for this at-risk population. It will also include a consumer education component to help people better understand insurance terms, their choices, and the operation of insurance in the current marketplace.

The portal will guide Americans through a comprehensive landscape of insurance options across the private and public sectors. By helping people identify coverage that is best suited to them, it will give Americans more control over their own care and provide tools that enable more people to obtain health insurance between now and 2014.

How It Will Work

Because of the short time frame between passage of the Affordable Care Act and the requirement that the portal be available on July 1, the portal will launch in phases.

The first phase of the portal will be introduced by July 1 as required in the law. It will provide summary level information on available coverage options by state and zip code in the private market and information about public programs with links to more detailed information. It will be followed by a second phase in October that will have more detailed pricing and benefit information.

The more detailed pricing and benefit information does not yet exist in a central, easily accessible format. So before the portal can display this information, it must be collected from the insurance companies offering the plans. The Interim Final Rule (IFR) published to the Federal Register on Wednesday, May 5, 2010 provides guidance on what information will be collected, as well as when and how.

As more information becomes available and the Affordable Care Act is implemented, the features on the web portal will continue to evolve, and more sophisticated and advanced functions will be added.

July 1

In addition to its educational content and information on small business tax credits and the early retiree reinsurance program, the July 1 portal will provide the following information to enable consumers to evaluate their options in the private market.

- Plan names and types (e.g. HMO, PPO)
- Summary of services provided
- List of network providers
- Formulary if available
- Links to plan website
- Consumer contact information to get more information and enroll

For Medicare program, consumers will be referred to existing Medicare web sites and call centers.

For Medicaid and CHIP programs, consumers will be able to get the following information for the programs in their states.

- Eligibility information to determine if they or a family member may be eligible to enroll in these programs
- Summary of services available in these programs in their states through core programs as well as waiver programs
- Links and contact information to get more detailed benefit information, determine eligibility on an individual basis, and enroll

For the high risk pools, consumers will be able to get the following information on high risk pools in their states.

- Name and contact information for high risk pools for individual determinations of eligibility and enrollment
- Eligibility criteria for enrolling
- Coverage limitations
- General premium description

October

Starting in October, the web portal will provide more detailed pricing and benefit information on private insurance options. It will show cost-sharing per service, deductibles, and premiums. It will also have plan compare functionalities. This will be accomplished through a full and open competition for a contractor.

In addition, more detailed information will be provided on services covered by the state Medicaid and CHIP programs along with more detailed eligibility criteria. More information will be provided on the federal high risk pool program and state high risk pools, including more information on premiums and cost-sharing.

Fact Sheet: The Affordable Care Act's New Patient's Bill of Rights

June 22, 2010

A major goal of the Affordable Care Act – the health insurance reform legislation President Obama signed into law on March 23 – is to put American consumers back in charge of their health coverage and care. Insurance companies often leave patients without coverage when they need it the most, causing them to put off needed care, compromising their health and driving up the cost of care when they get it. Too often, insurance companies put insurance company bureaucrats between you and your doctor. The Affordable Care Act cracks down on the some of the most egregious practices of the insurance industry while providing the stability and the flexibility that families and businesses need to make the choices that work best for them.

Today, the Departments of Health and Human Services (HHS), Labor, and Treasury issued regulations to implement a new Patient's Bill of Rights under the Affordable Care Act – which will help children (and eventually all Americans) with pre-existing conditions gain coverage and keep it, protect all Americans' choice of doctors and end lifetime limits on the care consumers may receive. These new protections apply to nearly all health insurance plans.[1]

How These New Rules Will Help You

- **Stop insurance companies from limiting the care you need.** For most plans starting on or after September 23, these rules stop insurance companies from imposing pre-existing condition exclusions on your children; prohibit insurers from rescinding or taking away your coverage based on an unintentional mistake on an application; ban insurers from setting lifetime limits on your coverage; and restrict their use of annual limits on coverage.

- **Remove insurance company barriers between you and your doctor.** For plans starting on or after September 23, these rules ensure that you can choose the primary care doctor or pediatrician you want from your plan's provider network, and that you can see an OB-GYN without needing a referral. Insurance companies will not be able to require you to get prior approval before seeking emergency care at a hospital outside your plan's network. These protections apply to health plans that are not grandfathered.

Builds On Other Affordable Care Act Policies

These new protections complement other parts of the Affordable Care Act including:

- **Reviewing Insurers' Premium Increases.** HHS recently offered States $51 million in grant funding to strengthen review of insurance premiums. Annual premium hikes can put insurance out of reach of many working families and small employers. These grants are a down-payment that enable States to act now on reviewing, disclosing, and preventing unreasonable rate hikes. Already, a number of States, including California, New York, Maine, Pennsylvania and others are moving forward to improve their oversight and require more transparency of insurance companies' requests to raise rates.

- **Getting the Most from Your Premium Dollars.** Beginning in January, the Affordable Care Act requires individual and small group insurers to spend at least 80% and large group insurers to spend at least 85% of your premium dollars on direct medical care and efforts to improve the quality of care you receive – and rebate you the difference if they fall short. This will limit spending on overhead and

salaries and bonuses paid to insurance company executives and provide new transparency into how your dollars are spent. Insurers will be required to publicly disclose their rates on a new national consumer website – HealthCare.gov.

- **Keeping Young Adults Covered.** Starting September 23, children under 26 will be allowed to stay on their parent's family policy, or be added to it. Group health plans that are grandfathered plans can limit this option to adult children that don't have another offer of employment-based coverage. Many insurance companies and employers have agreed to implement this program early, to avoid a gap in coverage for new college graduates and other young adults.

- **Providing Affordable Coverage to Americans without Insurance due to Pre-existing Conditions:** Starting July 1, Americans locked out of the insurance market because of a pre-existing condition can begin enrolling in the Pre-existing Condition Insurance Plan (PCIP). This program offers insurance without medical underwriting to people who have been unable to get it because of a preexisting condition. It ends in 2014, when the ban on insurers refusing to cover adults with pre-existing conditions goes into effect and individuals will have affordable choices through Exchanges – the same choices as members of Congress.

New Consumer Protections Starting As Early As This Fall

The new Patient's Bill of Rights regulations detail a set of protections that apply to health coverage starting on or after September 23, 2010, six months after the enactment of the Affordable Care Act. They are:

- **No Pre-Existing Condition Exclusions for Children Under Age 19.** Each year, thousands of children who were either born with or develop a costly medical condition are denied coverage by insurers. Research has shown that, compared to those with insurance, children who are uninsured are less likely to get critical preventive care including immunizations and well-baby checkups. That leaves them twice as likely to miss school and at much greater risk of hospitalization for avoidable conditions.

    - A Texas insurance company denied coverage for a baby born with a heart defect that required surgery. Friends and neighbors rallied around the family to raise the thousands of dollars needed to pay for the surgery and put pressure on the insurer to pay for the needed treatment. A week later the insurer backed off and covered the baby.[2]

The new regulations will prohibit insurance plans from denying coverage to children based on a pre-existing conditions. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for a child with cancer because the child had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the family for the child because of the child's pre-existing medical condition). These protections will apply to all types of insurance except for individual policies that are "grandfathered," and will be extended to Americans of all ages starting in 2014.

- **No Arbitrary Rescissions of Insurance Coverage.** Right now, insurance companies are able to retroactively cancel your policy when you become sick, if you or your employer made an unintentional mistake on your paperwork.

    - In Los Angeles, a woman undergoing chemotherapy had her coverage cancelled by an insurer who insisted her cancer existed before she bought coverage. She faced more than $129,000 in medical bills and was forced to stop chemotherapy for several months after her insurance was rescinded.[3]

Under the regulations, insurers and plans will be prohibited from rescinding coverage – for individuals or groups of people – except in cases involving fraud or an intentional misrepresentation of material facts. Insurers and plans seeking to rescind coverage must provide at least 30 days advance notice to give people time to appeal. There are no exceptions to this policy.

- **No Lifetime Limits on Coverage.** Millions of Americans who suffer from costly medical conditions are in danger of having their health insurance coverage vanish when the costs of their treatment hit lifetime limits set by their insurers and plans. These limits can cause the loss of coverage at the very moment when patients need it most. Over 100 million Americans have health coverage that imposes such lifetime limits.
    - A teenager was diagnosed with an aggressive form of leukemia requiring chemotherapy and a stay in the intensive care unit. He reached his family's plan's $1 million lifetime limit in less than a year. His parents had to turn to the public for help when the hospital informed them it needed either $600,000 in certified insurance or a $500,000 deposit to perform the bone marrow transplant he needed.[4]

The regulation released today prohibits the use of lifetime limits in all health plans and insurance policies issued or renewed on or after September 23, 2010.

- **Restricted Annual Dollar Limits on Coverage.** Even more aggressive than lifetime limits are annual dollar limits on what an insurance company will pay for health care. Annual dollar limits are less common than lifetime limits, involving 8 percent of large employer plans, 14 percent of small employer plans, and 19 percent of individual market plans. But for people with medical costs that hit these limits, the consequences can be devastating.
    - One study found that 10 percent of cancer patients reached a limit of what insurance would pay for treatment – and a quarter of families of cancer patients used up all or most of their savings on treatment.[5]

The rules will phase out the use of annual dollar limits over the next three years until 2014 when the Affordable Care Act bans them for most plans. Plans issued or renewed beginning September 23, 2010, will be allowed to set annual limits no lower than $750,000. This minimum limit will be raised to $1.25 million beginning September 23, 2011, and to $2 million beginning on September 23, 2012. These limits apply to all employer plans and all new individual market plans. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited

Employers and insurers that want to delay complying with these rules will have to win permission from the Federal government by demonstrating that their current annual limits are necessary to prevent a significant loss of coverage or increase in premiums. Limited benefit insurance plans – which are often used by employers to provide benefits to part-time workers — are examples of insurers that might seek this kind of delay. These restricted annual dollar limits apply to all insurance plans except for individual market plans that are grandfathered.

- **Protecting Your Choice of Doctors.** Being able to choose and keep your doctor is a key principle of the Affordable Care Act, and one that is highly valued by Americans. People who have a regular primary care provider are more than twice as likely to receive recommended preventive care; are less likely to be hospitalized; are more satisfied with the health care system, and have lower costs. Yet, insurance companies don't always make it easy to see the provider you choose.

One survey found that three-fourths of OB-GYNs reported that patients needed to return to their primary care physicians for permission to get follow-up care.

The new rules make clear that health plan members are free to designate any available participating primary care provider as their provider. The rules allow parents to choose any available participating pediatrician to be their children's primary care provider. And, they prohibit insurers and employer plans from requiring a referral for obstetrical or gynecological (OB-GYN) care. All of these provisions will improve people's access to needed preventive and routine care, which has been shown to improve the health of those treated and avoid unnecessary health care costs. These policies apply to all individual market and group health insurance plans except those that are grandfathered.

- **Removing Insurance Company Barriers to Emergency Department Services**. Some insurers will only pay for health care provided by a limited number or network of providers – including emergency health care. Others require prior approval before receiving emergency care at hospitals outside of their networks. This could mean financial hardship if you get sick or injured when you are away from home or not near a network hospital.

The new rules make emergency services more accessible to consumers. Health plans and insurers will not be able to charge higher cost-sharing (copayments or coinsurance) for emergency services that are obtained out of a plan's network. The rules also set requirements on how health plans should reimburse out-of-network providers. This policy applies to all individual market and group health plans except those that are grandfathered.

Benefits of Consumer Protections

The new rules will bring immediate relief to many Americans and provide peace of mind to millions more who are only one illness or accident away from medical and financial chaos.

The new ban on lifetime limits would affect group premiums by 0.5% or less and individual market premiums by 0.75% or less. The restricted annual limit policy would affect group and individual markets by roughly 0.1% or less (grandfathered individual market plans are exempt). And, the prohibition of preexisting conditions exclusions for children would affect group health plans by just a few hundredths of a percent. For new plans in the individual market, this impact would be roughly 0.5% in many states. In states with community rating, (roughly twenty states), the impact could be up to 1.0%. These costs are before taking into account benefits.

In addition, the rules will achieve greater cost savings by:

- **Reducing the"hidden tax" on insured Americans:** By making sure insurance covers people who are most at risk, there will be less uncompensated care and the amount of cost shifting among those who have coverage today will be reduced by up to $1 billion in 2013.

- **Improving Americans' health:** By making sure that high-risk individuals have insurance, the rules will reduce premature deaths.[6] Insured children are less likely to experience avoidable hospital stays than uninsured children[7] and, when hospitalized, insured children are at less risk of dying.[8]

- **Protecting Americans' savings:** High medical costs contribute to some degree to about half of the more than 500,000 personal bankruptcies in the U.S. in 2007.[9] These costs borne by individuals might be assumed by insurance companies once rescissions are banned, annual limits are restricted, lifetime limits are prohibited, and most children have access to health insurance without pre-existing condition exclusions.

- **Enhancing workers' productivity:** Making sure that kids with health problems have coverage will reduce the number of days parents have to take off from work to care for family members. Parents will also be freed from "job lock," which occurs when people are afraid to take a better job because they might lose coverage for themselves or their families.[10]

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[1] Limits on pre-existing conditions and annual limits will not apply to existing "grandfathered" plans offering individual coverage. For details, see the Fact Sheet and interim final regulations released on the topic on June 14.

[2] Jarvis, Jan, "Under Fire, Blue Cross Blue Shield of Texas Offers to Cover Medical Expenses for Crowley Baby," *Houston Star-Telegram*, (March 31, 2010).

[3] Girion, Lisa "Health Net Ordered to Pay $9 million after Canceling Cancer Patient's Policy," *Los Angeles Times* (2008), available at: http://www.latimes.com/business/la-fi-insure23feb23,1,5039339.story.

[4] Murphy, Tom. "Patients struggle with lifetime health insurance benefit caps," Los Angeles Times, July 2008.

[5] See "National Survey of Households Affected by Cancer." (2006) accessed at http://www.kff.org/kaiserpolls/upload/7591.pdf

[6] See, for example, Almond, Doyle, Kowalski, Williams (2010), Doyle (2005), and Currie and Gruber (1996).

[7] Keane, Christopher et al. "The Impact of Children's Health Insurance Program by Age." *Pediatrics* 104:5 (1999), available at: http://pediatrics.aappublications.org/cgi/reprint/104/5/1051..

[8] Bernstein, Jill et al. "How Does Insurance Coverage Improve Health Outcomes?" *Mathematica Policy Research* (2010), available: http://www.mathematica-mpr.com/publications/PDFs/Health/Reformhealthcare_IB1.pdf

[9] David Himmelstein et al, 2009.

[10] Gruber, J. and B. Madrian. "Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature." (2001).

Fact Sheet: The Affordable Care Act:
Protecting Consumers and Putting Patients Back in Charge of Their Care
July 22, 2010

The Affordable Care Act will help support and protect consumers and end some of the worst insurance company abuses. For too long, consumers have been forced to fend for themselves in a health care system that did not provide them with the support and assistance they needed and deserved. Today, the Obama Administration is announcing new regulations that will allow consumers to appeal decisions made by their health plans and the availability of resources that will be used to help give consumers more control of their health care decisions. Today's announcements include:

- **New regulations that give consumers in new health plans in every State the right to appeal decisions, including claims denials and rescissions, made by their health plans.**[1] The rules issued by the Departments of Health and Human Services, Labor, and the Treasury give consumers:

    - The right to appeal decisions made by their health plan through the plan's internal process,

    - For the first time, the right to appeal decisions made by their health plan to an outside, independent decision-maker, no matter what State they live in or what type of health coverage they have. States will work to establish or update their external appeals process to meet new standards, and consumers who are not protected by a State law will have access to a Federal external review program.

  Next year, an estimated 31 million people in new employer plans and 10 million people in new individual plans will benefit from the new appeals rights announced today. The number of individuals in employer plans who will benefit is expected to rise to 78 million by 2013, for a total potential of 88 million Americans who will be guaranteed the right to appeal decisions made by their health plan.

- **A $30 million grant program to establish and strengthen consumer assistance offices in States and Territories.** The new Consumer Assistance Grants Program will help States establish consumer assistance offices or strengthen existing ones. The new funds will be used to provide consumers with the information they need to pick from a range of coverage options that best meets their needs.

<u>New Regulations To Help Consumers Appeal Decisions By Their Health Plans</u>

[1] To help individuals who like the coverage they have keep it, some plans that were in effect on March 23, 2010, and that were not significantly modified thereafter will be "grandfathered." Grandfathered health plans are not subject to these regulations. For more information about the definition of a grandfathered plan, see http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html.

The new rules issued by the Departments of Health and Human Services, Labor, and the Treasury will standardize both an internal process and an external process that patients can use to appeal decisions made by their health plan.

Today, if your health plan tells you it won't cover a treatment your doctor recommends, or it refuses to pay the bill for your child's last trip to the emergency room, you may not know where to turn. Most health plans have a process that lets you appeal the decision within the plan through an "internal appeal" – but depending on your State's laws and your type of coverage, there's no guarantee that the process will be swift and objective. Moreover, if you lose your internal appeal, you may not be able to ask for an "external appeal" to an independent reviewer.

The rules issued today will end the patchwork of protections that apply to only some plans in some States, and simplify the system for consumers. And they will ensure that all consumers in new health plans have access to internal and external appeals processes that are clearly defined, impartial, and designed to ensure that, when health care is needed and covered, consumers get it.

Internal Appeals

The internal appeals process will guarantee a venue where consumers may present information their health plan might not have been aware of, giving families a straightforward way to clear up misunderstandings. Under the new rules, new health plans beginning on or after September 23, 2010 must have an internal appeals process that:

- Allows consumers to appeal when a health plan denies a claim for a covered service or rescinds coverage;
- Gives consumers detailed information about the grounds for the denial of claims or coverage;
- Requires plans to notify consumers about their right to appeal and instructs them on how to begin the appeals process;
- Ensures a full and fair review of the denial; and
- Provides consumers with an expedited appeals process in urgent cases.

External Appeals

If a patient's internal appeal is denied, patients in new plans will have the right to appeal all denied claims to an independent reviewer not employed by their health plan. External appeals have helped consumers get the care they deserve: one study found that – in States that had external appeals – consumers won their external appeal against the insurance company 45% of the time.[2]

While 44 States provide for some form of external appeal, the laws governing these processes vary greatly and fail to cover millions of Americans. The new rules will ensure that consumers with new health coverage in all States have access to a standard external appeals process that meets high standards for full and fair review.

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[2] Kaiser Family Foundation, *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation*, 2002. http://www.kff.org/insurance/externalreviewpart2rev.pdf.

These standards were established by the National Association of Insurance Commissioners (NAIC). States are encouraged to make changes in their external appeals laws to adopt these standards before July 1, 2011. The NAIC standards call for:

- **External review of plan decisions** to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- **Clear information** for consumers about their right to both internal and external appeals – both in the standard plan materials, and at the time the company denies a claim.
- **Expedited access** to external review in some cases – including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
- **Health plans must pay the cost of the external appeal** under State law, and States may not require consumers to pay more than a nominal fee.
- **Review by an independent body** assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
- **Emergency processes for urgent claims**, and a process for experimental or investigational treatment.
- **Final decisions must be binding** so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.

If State laws don't meet these standards, consumers in those States will be protected by comparable Federal external appeals standards. In addition, people in health plans that are not subject to State law – including new self-insured employer plans – will be protected by the new Federal standards.

New Consumer Assistance Grants

The Affordable Care Act provides consumers with significant new protections including the ability to choose a health plan that best suits their needs, to appeal decisions by plans to deny coverage of needed services, and to select an available primary care provider of their choosing. The new Consumer Assistance Grants program will provide nearly $30 million in new resources to help States and Territories educate consumers about their health coverage options, empower consumers, and ensure access to accurate information. Grants will be made available to support States' efforts to establish or strengthen consumer assistance programs that provide direct services to consumers with questions or concerns regarding their health insurance.

All States and Territories may apply for these grants, which will help expand consumer assistance efforts on the State level, including:

- Helping consumers enroll in health coverage;
- Helping consumers file complaints and appeals against health plans;
- Educating consumers about their rights and empowering them to take action; and
- Tracking consumer complaints to help identify problems and strengthen enforcement.

Eligible applicants include State insurance departments, State attorneys general offices, independent State consumer assistance agencies, or other State agencies. States and Territories may also partner with non-profit organizations that have a track record of working with consumers. Applications are available now by visiting www.Grants.gov and searching for CFDA number 93.519.

What Will This Mean for You?

- Under these rules, if your health plan denies coverage of a test – for example an MRI – you and your doctor can appeal that decision to the plan and, if the plan still refuses to cover the test, to an external reviewer. If the external reviewer agrees with you, your plan must pay for the test.

- If your plan decides to rescind your coverage altogether based on the fact that information on your application for coverage was not accurate, you can appeal that decision. If your appeal is successful, the plan must reinstate your coverage.

- If you go to the emergency room and your plan won't pay the bill, you'll have the chance to provide information to the plan about why you needed emergency care – and take your request to an external reviewer if your appeal to the plan is denied.

Consumer Assistance Grants have the potential to benefit millions of Americans. These grants will fund programs that will support consumers both now as we transition to a more competitive, patient-centered health insurance marketplace in 2014 and once that new marketplace is established**.**

- If you learn that your employer is cancelling coverage, and you know it will be hard to find coverage for your family on the individual market, you may need someone to help explain your options. A State consumer assistance program will provide that support, helping you figure out what you need, describing ways you can get coverage, and ultimately helping you enroll in coverage.

- Just last year, one State's existing consumer assistance program helped nearly 3,000 residents and recovered over $7 million in benefits on behalf of consumers. In another State, a similar program assisted about 13,000 residents and helped nearly 8,000 of them enroll in coverage.

Builds on Other Initiatives to Protect Patients' Rights

The rules released today build on a series of efforts under the Affordable Care Act to strengthen consumer and patient rights. Other actions include:

- **Prohibiting Insurance Companies from Rescinding Coverage**. In the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny coverage when he or she got sick. The new law makes this practice illegal.

- **Extending Coverage for Young Adults.** Under the new law, starting next year, young adults will be allowed to stay on their parent's plan until they turn 26 years old. (In the case of grandfathered group health plans, this right does not apply if the young adult has available health coverage at work.) Some plans have begun implementing this policy early. Check with your insurance company or employer to see if you qualify.

- **Eliminating Lifetime Limits on Coverage.** Under the new law, health plans will be prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays.

- **Regulating Annual Dollar Limits on Insurance Coverage.** Under the new law, health plans' use of annual dollar limits on the amount of insurance coverage a patient may receive will be restricted for new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans.

- **Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions**. The law prohibits insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition.

Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions

July 27, 2010

On June 28, 2010, the Administration published the interim final regulations prohibiting new group health plans and health insurance issuers 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. These regulations apply to grandfathered group health plans and group health insurance coverage but do not apply to grandfathered individual health insurance coverage that was in existence on March 23, 2010.

Accordingly, 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. These questions and answers will assist issuers with implementation of this requirement.

Question #1: Will children in child-only individual market health plans today 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 today are unlikely to be affected by the new policies.

Question #2: Do these interim final rules require issuers in the individual health insurance market to offer children under 19 non-grandfathered family and individual coverage at all times during the year?

A: No. To address concerns over adverse selection, issuers 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.

Question #3: How often must an issuer in the individual market provide an open enrollment period for children under 19?

A: Unless State laws provide such guidance, issuers 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 the pre-existing condition exclusion policy for children and issue further guidance on open enrollment periods if it appears that their use is limiting the access intended under the law.

Question #4: How do these rules affect existing enrollment requirements in States that already require guaranteed issue of coverage for children under 19 in the individual market?

A: If a State requires continuous open enrollment or requires issuers 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 preempted by any current federal requirements.

Question #5: "Premium assistance" programs allow States to provide payments to help people eligible for Medicaid and Children's Health Insurance Programs (CHIP) enroll in private coverage. Won't the policy to ban pre-existing condition exclusions in new plans for children lead cash-strapped States to steer high-cost children into individual market policies for children as a way to limit their own liability?

A: Federal law prohibits Medicaid and CHIP from denying children coverage based on their health status. Moreover, it limits the extent to which these programs can provide payment to support coverage in individual market policies. "Premium assistance" programs in CHIP allow States to provide payment to private policies to cover children if doing so both protects children and is cost effective to the Federal and State governments. Premium assistance is not designed as a strategy to transfer vulnerable children to individual market coverage. The Administration will enforce its current policies on premium assistance and consider new ones if evidence emerges that children with pre-existing conditions are being diverted inappropriately from Medicaid or CHIP to private insurance plans that newly offer guaranteed issue to children regardless of their health status.

Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Families and Businesses

The Affordable Care Act allows young adults to stay on their parents' health care plan until age 26. Before the President signed this landmark Act into law, many health plans and issuers could and did in fact remove young adults from their parents' policies because of their age, leaving many college graduates and others with no insurance. This helps to explain problems like:

- **Young adults have the highest rate of uninsured of any age group.** About 30% of young adults are uninsured, representing more than one in five of the uninsured. This rate is higher than any other age group, and is three times higher than the uninsured rate among children.
- **Young adults have the lowest rate of access to employer-based insurance.** As young adults transition into the job market, they often have entry-level jobs, part-time jobs, or jobs in small businesses, and other employment that typically comes without employer-sponsored health insurance. The uninsured rate among employed young adults is one-third higher than older employed adults.
- **Young adults' health and finances are at risk.** Contrary to the myth that young people don't need health insurance, one in six young adults has a chronic illness like cancer, diabetes or asthma. Nearly half of uninsured young adults report problems paying medical bills.

Providing Relief for Young Adults

The Affordable Care Act requires plans and issuers that offer coverage to children on their parents' plan to make the coverage available until the adult child reaches the age of 26. Many parents and their children who worried about losing health insurance after the children moved away from home or graduated from college no longer need to worry.

The Departments of Health and Human Services, Labor, and Treasury have issued regulations implementing the Affordable Care Act by expanding dependent coverage for adult children up to age 26. Key elements include:

- **Coverage Extended to More Children.** The goal of this new policy is to cover as many young adults under the age of 26 as possible with the least burden. Plans and issuers that offer dependent coverage must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. There is a transition for certain existing group plans that generally do not have to

provide dependent coverage until 2014 if the adult child has another offer of employer-based coverage aside from coverage through the parent. The new policy providing access for young adults applies to both married and unmarried children, although their own spouses and children do not qualify.

- **Effective for Plan or Policy Years Beginning On or After September 23, 2010.** Secretary Kathleen Sebelius called on leading insurance companies to begin covering young adults voluntarily before the implementation date required by the Affordable Care Act (which is plan or policy years beginning on or after September 23rd). Early implementation would avoid gaps in coverage for new college graduates and other young adults and save on insurance company administrative costs of dis-enrolling and re-enrolling them between May 2010 and September 23, 2010. Over 65 companies have responded to this call saying they will voluntarily continue coverage for young adults who graduate or age off their parents' insurance before the implementation deadline.
- **All Eligible Young Adults Will Have A Special Enrollment Opportunity.** For plan or policy years beginning on or after September 23, 2010, plans and issuers must give children who qualify an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan or policy year beginning on or after September 23, 2010. The new policy does not otherwise change the enrollment period or start of the plan or policy year.
- **Same Benefits/Same Price.** Any qualified young adult must be offered all of the benefit packages available to similarly situated individuals who did not lose coverage because of cessation of dependent status. The qualified individual cannot be required to pay more for coverage than those similarly situated individuals. The new policy applies only to health insurance plans that offer dependent coverage in the first place: while most insurers and employer-sponsored plans offer dependent coverage, there is no requirement to do so.
- **Affordable Premiums.** According to an analysis of this provision, adding young adult coverage would increase average family premiums by as little as .7% while allowing 1.2 million young Americans coverage under their parents' plan through an employer or the individual market.

Access to Insurance: What Young Adults and Parents Need to Do:

- **Check for Immediate Options:** Private health insurance companies that cover the majority of Americans have volunteered to provide coverage earlier than the implementation deadline for young adults losing coverage as a result of graduating from college or aging out of dependent coverage on a family policy. This stop-gap coverage, in many cases, is available now. Ask your employer and insurer about this option.
- **Watch for Open Enrollment:** If early coverage is not an option with your employer or insurance company, then young adults will qualify for an open enrollment period to join their parents' family plan or policy beginning on or after

September 23, 2010. Insurers and employers are required to provide notice for this special open enrollment period. Watch for it or ask about it.

- **Expect an Offer of Continued Enrollment:** Insurers and employers that sponsor health plans will inform young adults of continued eligibility for coverage until the age of 26. To get the coverage, young adults and their parents need not do anything but sign up and pay for this option.

New Tax Benefits for Adult Child Coverage

The new regulation complements guidance issued by the Treasury Department on April 27, 2010, on the tax benefits provided for such coverage through the Affordable Care Act. Under a new tax provision in the Affordable Care Act and the Treasury guidance, the value of any employer-provided health coverage for an employee's child is excluded from the employee's income through the end of the taxable year in which the child turns 26. This tax benefit applies regardless of whether the plan is required by law to extend health care coverage to the adult child or the plan voluntarily extends the coverage.

Key elements include:

- **Tax Benefit Continues Beyond Extended Coverage Requirement.** While the Affordable Care Act requires health care plans to cover enrollees' children up to age 26, some employers may decide to continue coverage beyond the child's 26th birthday. In such a case, the Act provides that the value of the employer-provided health coverage is excluded from the employee's income for the entire taxable year in which the child turns 26. Thus, if a child turns 26 in March but stays on the plan through December 31st (the end of most people's taxable year), all health benefits provided that year are excluded for income tax purposes.
- **Available Immediately.** These tax benefits are effective March 30, 2010. The exclusion applies to any coverage that is provided to an adult child from that date through the end of the taxable year in which the child turns 26.
- **Broad Eligibility.** This expanded health care tax benefit applies to various workplace and retiree health plans. It also applies to self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return.
- **Both Employer and Employee Shares of Health Premium Are Excluded from Income.** In addition to the exclusion from income of any employer contribution towards qualifying adult child coverage, employees can receive the same tax benefit if they contribute toward the cost of coverage through a "cafeteria plan." This benefit is available immediately, even if the cafeteria plan document has not yet been amended to reflect the change. To reduce the burden on employers, they have until the end of 2010 to amend their cafeteria plan documents to incorporate this change.

Companies Responding To Secretary Sebelius' Call For Early Implementation:

Early implementation by the companies listed below will avoid gaps in coverage for new college graduates and other young adults and save on insurance company administrative costs of dis-enrolling and re-enrolling them between May 2010 and the start of the plan or policy year beginning on or after September 23, 2010. Early enrollment will also enable young, overwhelmingly healthy people who will not engender large insurance costs to stay in the insurance pool. The following companies have agreed to implement this program before the September 23, 2010 deadline:

Coventry Healthcare, Inc.
Blue Cross and Blue Shield of Alabama
Blue Cross Blue Shield of Delaware
Blue Cross and Blue Shield of Arizona, Inc.
Blue Cross and Blue Shield of Florida
Arkansas Blue Cross and Blue Shield
Blue Cross and Blue Shield of Hawaii
Blue Shield of California
Blue Cross of Idaho Health Service
Regence Blue Shield of Idaho
Wellmark Blue Cross and Blue Shield of Iowa
Health Care Service Corporation
Blue Cross and Blue Shield of Kansas
Blue Cross Blue Shield Association
Blue Cross and Blue Shield of Louisiana
WellPoint, Inc.
CareFirst BlueCross and BlueShield
Blue Cross and Blue Shield of Massachusetts
Blue Cross and Blue Shield of Kansas City
Blue Cross and Blue Shield of Michigan
Blue Cross and Blue Shield of Montana
Blue Cross and Blue Shield of Minnesota
Blue Cross and Blue Shield of Nebraska
Blue Cross & Blue Shield of Mississippi
Horizon Blue Cross and Blue Shield of New Jersey, Inc.
HealthNow New York, Inc.
The Regence Group
Excellus Blue Cross and Blue Shield
Capital BlueCross
Blue Cross and Blue Shield of North Carolina
Independence Blue Cross
BlueCross BlueShield of North Dakota
Highmark, Inc.
Blue Cross of Northeastern Pennsylvania
BlueCross and BlueShield of Tennessee
Blue Cross and Blue Shield of Vermont
Blue Cross & Blue Shield of Rhode Island
Premera Blue Cross

Blue Cross and Blue Shield of South Carolina
Blue Cross and Blue Shield of Wyoming
Kaiser Permanente
Cigna
Aetna
United
WellPoint
Humana
Capital District Physicians' Health Plan (CDPHP), Albany, New York
Capital Health Plan, Tallahassee, Florida
Care Oregon, Portland, Oregon
Emblem Health, New York, New York
Fallon Community Health Plan, Worcester, Massachusetts
Geisinger Health Plan, Danville, Pennsylvania
Group Health, Seattle, Washington
Group Health Cooperative Of South Central Wisconsin, Madison, Wisconsin
Health Partners, Minneapolis, Minnesota
Independent Health, Buffalo, New York
Kaiser Foundation Health Plan Oakland, California
Martin's Point Health Care, Portland, Maine
New West Health Services, Helena, Mt
The Permanente Federation, Oakland, California
Priority Health, Grand Rapids, Michigan
Scott & White Health Plan, Temple, Texas
Security Health Plan, Marshfield, Wisconsin
Tufts Health Plan, Waltham, Massachusetts
UCARE, Minneapolis, Minnesota
UPMC Health Plan, Pittsburgh, Pennsylvania

To View Frequently Asked Questions.

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

NEWS RELEASE

FOR IMMEDIATE RELEASE

For more information contact: Alice Jones
Public Information Manager
(501) 371-2835
alice.jones@arkansas.gov

Application for Coverage In New Pre-Existing Condition Insurance Plan Begins August 1, 2010

LITTLE ROCK, ARKANSAS (July 20, 2010) ─ Insurance Commissioner Jay Bradford announced today that starting August 1, 2010, Arkansans will be able to apply for a new Pre-Existing Condition Insurance Plan (PCIP) for people who have been uninsured for at least six months and denied coverage for pre-existing conditions. The PCIP has been created as required by the Patient Protection and Affordable Care Act (PPACA) signed by President Obama on March 23, 2010. Under the new law the Secretary of the U.S. Department of Health and Human Services must create temporary federal high risk pools in every state, which are administered either by a state, a non-profit entity or directly by the federal government. PCIP is the name of the coverage offered by this federal pool. Arkansas is one of 30 states that elected to administer its own pool through the Arkansas Comprehensive Health Insurance Pool (CHIP), which already provides similar risk pool plans to Arkansas residents. The PCIP will operate until 2014 and is one of the first concrete results from the health care reform legislation. Arkansas will receive $46 million of the $5 billion being provided nationwide by the federal government to fund the PCIP. The federal high risk pool and the existing CHIP pools will continue to operate separately as required by PPACA.

To qualify for the PCIP, an individual must be an Arkansas resident and have been turned down for health insurance because of a pre-existing condition, or have been offered coverage that excludes the pre-existing condition. "The applicant must not have had coverage for the past six months," Bradford said. In the PCIP's first year of operation, Arkansas will limit enrollment to 2,500. Thereafter, the plan's claims experience will be reviewed to determine whether coverage can

(MORE)

be expanded. The PCIP will cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. All covered benefits are available to participants, including pre-existing conditions. Covered individuals will pay premiums for a $1,000 deductible plan with a $2,000 out-of-pocket maximum that will vary depending on age and whether the covered individual uses tobacco products. For non-tobacco users, premiums will range from $156 to $624 per month.

The PCIP will be administered through Blue Advantage Administrators, which is part of Arkansas Blue Cross and Blue Shield. Blue Advantage already administers CHIP. Information regarding application to the PCIP will be distributed to health insurance agents throughout the state in the next week, and applications will be available on August 1, 2010. Coverage will commence on September 1, 2010, for qualifying applicants.

For further information about this program, please call (800) 285-6477 or email chiparkansas@arkbluecross.com.

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New Federal Pre-existing Condition Insurance Plan available for uninsured in Arkansas

If you have had a problem getting health insurance due to a pre-existing condition and have been uninsured for at least the past six months, you need to know about the new Federal Pre-existing Condition Insurance Plan (PCIP).

PCIP is offered through the temporary federal risk pool created by the Patient Protection and Affordable Care Act. Premium payments for PCIP enrollees will be about the same as what an average person pays in the individual health insurance market and will vary by age and whether or not you use tobacco products. The cost of the program is subsidized by federal funds.

The new PCIP will provide health insurance coverage for up to 2,500 Arkansans for a limited time, based on availability of federal funding. The plan will not deny any applicant coverage or benefits simply because of health status. The PCIP coverage is expected to last until 2014, when similar coverage will be available through health insurance exchanges.

(Continued on back)

FEDERAL
PRE-EXISTING CONDITION INSURANCE PLAN

1-800-285-6477

www.chiparkansas.org

Enrollment begins August 1, 2010!

Here's what you need to know about PCIP and how to apply:

Who is eligible for PCIP?

To qualify for the PCIP coverage you must:

- Be a resident of Arkansas and either a U.S. citizen or national or an alien lawfully present in the United States
- Within the past 6 months, have been denied coverage in Arkansas due to health conditions, or have been offered coverage in Arkansas with a rider excluding certain health conditions
- Have been uninsured for 6 months prior to submitting your application

What does PCIP cover?

PCIP offers many if not all of the same benefits you'd get from a private health insurance plan. This includes:

- Prescription drug coverage
- Care in medical offices for illness or injury
- Emergency services
- Inpatient and outpatient hospital services
- Coverage for pregnancy
- Certain transplants
- Diabetes treatment, equipment and supplies
- Home health care, skilled nursing and hospice care
- Outpatient rehabilitative services
- Wellness services and screening
- Behavioral health services
- Inpatient and outpatient mental health and substance abuse services
- And more

What plan benefit options are available?

PCIP is an individual, comprehensive major medical policy with an annual deductible of $1,000. Your annual out-of-pocket maximum for services performed by network providers is $2,000. Prescription drug coverage has $10, $30 and $70 copayments based on the medication drug list (formulary).

Applying for PCIP is easy!

- Contact your licensed insurance agent who can help you complete and submit an application.
- Apply directly by mailing an application to:
  Federal Pre-existing Condition Insurance Plan,
  c/o CHIP, P.O. Box 1460, Little Rock, AR 72203.
  Please call **1-800-285-6477** or e-mail **chiparkansas@arkbluecross.com** to request an application.

NOTE: Applications will be accepted on a first-come, first-served basis. Applications must be complete with all necessary documentation to verify the applicant's eligibility and must include the first premium payment. Incomplete applications will be reprocessed based on the date that all information is received. All applications must be received by PCIP through the U.S. Mail. Applications cannot be accepted by fax, e-mail, hand delivery, or any other means.

FEDERAL
PRE-EXISTING CONDITION
INSURANCE PLAN
P. O. Box 1460
Little Rock, AR 72203

Applicant's Name

Application for Coverage Under the Federal High Risk Pool

administered by the Arkansas Comprehensive Health Insurance Pool (CHIP)

This Application for coverage through the Pre-Existing Condition Insurance Plan ("PCIP") contains an Eligibility Worksheet and an Enrollment Form. The Eligibility Worksheet explains who may be eligible for PCIP and asks questions to help you figure out if you are eligible for coverage. Please contact local PCIP Customer Service at 1-800-285-6477 if you have questions about the Application.

Please send your completed Eligibility Worksheet and Enrollment Form to: PCIP, c/o CHIP, P.O. Box 1460, Little Rock, AR 72203.

Send payment with your Application. Your first premium payment is due with this Application. Please review the Rate Sheet to determine the amount of your monthly premium. Failure to send your first premium payment along with the submission of your Application will delay processing. Premium payments may be monthly or quarterly, at your option.

SPECIAL NOTIFICATION

1. **PCIP is a temporary federal high risk pool anticipated to provide coverage from 9/1/10 through 12/31/13. The PCIP is funded solely by the federal government and enrollee premiums. Funds are limited.**
2. **PCIP is not funded by CHIP or the State of Arkansas.**
3. **Enrollment for PCIP in Arkansas will be capped at 2,500.**
4. **Individuals whose complete Applications are received after the cap of 2,500 has been reached will be placed on a waiting list and premiums will be returned.**
5. **Applications may only be submitted via U.S. Mail.**
6. **Applications will be processed on a first come, first serve basis—based on date of receipt by CHIP. Applications received on a particular day will be processed in the order of postmark date.**

ELIGIBILITY WORKSHEET

To be eligible for PCIP coverage in Arkansas you must:

1. Be a resident of Arkansas;

AND

2. Be a citizen or national of the United States or an alien lawfully present in the United States;

AND

3. Have not been covered under Creditable Coverage* at any point during the 6-month period prior to the date of this Application;

AND

4. During the past 6 months:

   - have been declined individual health coverage in Arkansas; or
   - have been offered individual health coverage in Arkansas with a rider excluding a pre-existing medical condition.

Eligibility questions begin on the next page.

* Question 3 on the following page describes the various forms of health coverage that are "Creditable Coverage" under federal law.

Applicant's Name

GENERAL ELIGIBILITY QUESTIONS

1. **Residency:** Are you a resident of the State of Arkansas?

   ❑ Yes ❑ No

   If you answered YES, you MUST attach proof of residency, then continue with question 2.

   Proof of residency includes written evidence such as a copy of your current driver's license, your most recent Arkansas tax return or your utility bill.

   If you answered NO, **STOP**. You are not eligible for PCIP coverage.

2. **Citizenship or Immigration Status.** Are you a citizen or national of the United States or an alien lawfully present in the United States? ❑ Yes ❑ No

   If you answered YES, you MUST attach proof of your status, then continue with question 3.

   - If a U.S. citizen, provide your Social Security Number on the application form that follows this Eligibility Worksheet.
   - If a U.S. national, provide a copy of a document that confirms your status as a noncitizen national, such as a copy of your U.S. passport.
   - If a lawfully present alien, you must provide a copy of your immigration document, including a document that has your Alien Registration Number or I-94 Number. Acceptable documents include a copy of the following:
     - o I-327 (Reentry Permit)
     - o I-551 (Permanent Resident Card
     - o I-571 (Refuge Travel Document)
     - o I-766 (Employment Authorization Document)
     - o Machine Readable Immigrant Visa (with Temporary I-551 language) affixed to Unexpired Foreign Passport
     - o I-94 (Arrival/Departure Record) with unexpired Foreign Passport
     - o Unexpired Foreign Passport for Visa Waiver Program travelers
     - o I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and an Unexpired Foreign Passport
     - o DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and an Unexpired Foreign Passport
     - o Other document with an I-94 or Alien Number

3. **Uninsured by Creditable Coverage within the last 6 months.** At any point in the last 6 months prior to the date you submit this application, have you had any of the following types of coverage? You must answer each question.
   - Individual or job-based health plan, including COBRA or conversion coverage? ❑ Yes ❑ No
   - Medicare (Part A and/or Part B)? ❑ Yes ❑ No
   - Medicaid? ❑ Yes ❑ No
   - ARKids or another state's Children's Health Insurance Program? ❑ Yes ❑ No
   - A state high risk pool such as the state plans offered by CHIP? ❑ Yes ❑ No
   - TRICARE (military health insurance) ❑ Yes ❑ No
   - Health insurance provided by a public health plan established by a state, the U.S. government such as coverage provided by the VA to veterans, or foreign country? ❑ Yes ❑ No
   - FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation Coverage? ❑ Yes ❑ No
   - A health benefit plan provided to Peace Corps workers? ❑ Yes ❑ No
   - Services provided by the Indian Health Service or by a tribe or tribal organization for treating your medical condition? ❑ Yes ❑ No

   If you answered YES, **STOP**. You are not eligible for PCIP coverage.

   If you answered NO, continue with question 4.

Applicant's Name

4. **Proof of pre-existing condition(s).** In the last 6 months, have you been denied coverage by an Arkansas individual health insurer or HMO or been offered coverage by an Arkansas individual insurer or HMO with a rider excluding a particular medical condition or conditions? ❑ Yes ❑ No

If you answered NO, **STOP**. You are not eligible for PCIP coverage.

If you answered YES, you MUST provide the following proof of your difficulties obtaining coverage because of a pre-existing condition:

- **Notice of Rejection:** If you have been rejected or refused by an insurer or HMO to issue individual health coverage in Arkansas within the last 6 months because of the existence or history of a medical condition, please attach a copy of the rejection notice from the insurer or HMO and **fill out the Enrollment Form** beginning on the next page.
- **Offer of Individual Coverage with Exclusionary Rider:** If you were offered individual health coverage by an insurer or HMO in Arkansas that contained a rider excluding particular medical condition(s), please attach a copy of the offer and **fill out the Enrollment Form** beginning on the following page.

End of Eligibility Worksheet. Enrollment Form begins on next page.

FEDERAL
PRE-EXISTING CONDITION
INSURANCE PLAN

P.O. Box 1460
Little Rock, AR 72203

Enrollment Form

Please Print All Information.

APPLICANT INFORMATION

LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	DEDUCTIBLE
						$1,000

MAILING ADDRESS AND CONTACT INFORMATION

Street or P.O. Box				Daytime Phone No.
City	State	Zip Code	County	Other Phone No.

RESIDENCE ADDRESS (If Different than Mailing Address)

Street			
City	State	Zip Code	County

E-mail address: _____

Would you like to receive information about your coverage from PCIP by e-mail? ❑ Yes ❑ No

BILLING MODE (Please Check One)

❑ Monthly Bank Draft (Monthly payment is by bank draft only. To sign up, you MUST sign the authorization form in your packet and submit a voided check. If you do not submit these items with your Application, you will be billed quarterly.)

❑ Quarterly (After initial billing with your acceptance letter, you will be billed for three months' premium due each January 1, April 1, July 1 and October 1.)

PERSONAL INFORMATION

Tobacco Use.

- If you do not answer the following question and are enrolled in PCIP, you will be charged the rates of a tobacco user.

Have you used tobacco products in the last 12 months, including any type of lighted pipe, cigar, cigarette or any other smoking equipment filled with tobacco, or any type of smokeless tobacco, such as snuff or chewing tobacco? ❑ Yes ❑ No

Disability

Do you receive Social Security Disability Insurance (SSDI)? ❑ Yes ❑ No If YES, list the date your SSDI began: _____

Have you filed for SSDI? ❑ Yes ❑ No If YES, list the date you filed: _____

IMPORTANT INFORMATION ABOUT BILLING AND PAYMENT

1. **Rates.** Your premiums may vary from other PCIP policyholders, depending on your age and whether you have used tobacco products in the last 12 months. Premium rates change on your "0" and "5" birthdays starting at age 30 (35, 40, 45, 50, etc.).
2. **Rate changes.** PCIP rates may change at other times as well. You will have 31 days' notice of any rate change.

CERTIFICATION

Please read carefully and sign on the next page at the end of this Certification..

I hereby apply for Pre-existing Condition Insurance Plan ("PCIP") coverage, as offered by the federal government and administered by CHIP in the State of Arkansas. I understand and agree to everything listed below:

- I certify that all the information I have provided in this Application (which includes the Eligibility Worksheet and this Enrollment Form) is true and complete. I understand that my coverage may be canceled or rescinded if CHIP determines that I have provided false information.
- I certify that as of the date I complete this Application, all information provided in the Eligibility Worksheet about residency, citizenship or immigration status, insurance coverage during the last six months and proof of pre-existing conditions is true and correct. I agree to cooperate with CHIP and its authorized subcontractors in verifying any and all information provided regarding my eligibility for this coverage.
- I have read and understand the Outline of Coverage provided with this Application.
- I understand that for my Application to be complete, I must submit all required documents necessary to verify information that has been provided in this Eligibility Worksheet and Enrollment Form. Failure to do so will delay processing of my Application and may affect enrollment into PCIP.
- I understand that if accepted, I will be issued a Policy that explains my rights and responsibilities as a PCIP enrollee and that failure to follow the requirements of the Policy may result in the cancelation of my coverage.

- I understand that if I do not pay premiums in full within 30 days after the due date, coverage will end as of the date payment was due.
- I understand that if I disenroll or my coverage is cancelled (for non-payment of premium, for example), I will not be able to reapply for enrollment for at least 6 months after my coverage ends, except when I lose coverage simply because I am moving from Arkansas to another state.
- I understand that if I obtain other health insurance, I am no longer eligible for PCIP and will immediately notify CHIP that I have other coverage.

Any person who knowingly presents false information in an Application for insurance, or knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and confinement in prison.

Signed at:	**City**	**State**	**ZIP**
Print Applicant's Name			
Applicant's Signature	**X**	**Date Signed**	

If you are a parent, legal guardian or authorized representative of the person applying for coverage, you must sign above and complete the information below:

LAST NAME	FIRST NAME	M.I.

MAILING ADDRESS AND CONTACT INFORMATION (if different from applicant)

Street or P.O. Box				Daytime Phone No.
City	State	Zip Code	County	Other Phone No.

My relationship to the person applying for coverage is: ❑ Parent ❑ Legal Guardian ❑ Other Authorized Representative
(We may require documentation of your relationship to the applicant)

Effective Date: Subject to availability of plan's enrollment limitations, an individual eligible for enrollment who submits a complete enrollment request by the 15th day of a month will have an effective date of the 1st day of the following month. A complete Application includes all required information and documentation required to complete processing.

Agent's Statement: I have a valid agent's or broker's license in the State of Arkansas for accident and health insurance. I have *assisted* the applicant in completing this Application for coverage in the Pre-Existing Condition Insurance Plan (PCIP). To the best of my knowledge and belief, the information contained in this Application and this affirmation statement is correct and complete. I certify that the applicant meets the PCIP eligibility standards.

Print Agent's Name	AR License No.	Social Security No.	Agency Name	AR License No.	Phone Number

Agent's Signature	Date	Address	City	St	ZIP

FOR OFFICE USE ONLY (Do NOT write in this space.)

Division No.: _____

Effective Date: _____

End of Enrollment Form. Mail this Enrollment Form with your Eligibility Worksheet to:

PCIP

c/o CHIP

P.O. Box 1460

Little Rock, Arkansas 72203

About the New Pre-Existing Condition Insurance Plan

The Affordable Care Act signed by President Obama in March creates a new program – the Pre-Existing Condition Insurance Plan (PCIP) program-- to make health insurance available to millions of Americans denied coverage by private insurance companies because of a pre-existing condition. Coverage for people living with such conditions as diabetes, asthma, cancer, and HIV/AIDS has often been priced out of the reach of most Americans who buy their own insurance, and this has resulted in a denial of coverage for millions. The Pre-Existing Condition Insurance Plan is designed to address these challenges by offering comprehensive coverage at a reasonable cost.

The PCIP program, which is administered by either your State or the Federal government, will provide a new option for you if you are a U.S. citizen or legal resident who has been uninsured for at least six months, have a pre-existing condition, and have been unable to obtain health coverage because of your health condition.

Regulations published July 30 establish standards necessary for the administration of the program and clarify certain issues not otherwise specified in the statute. These include, but are not limited to: required and excluded benefits; eligibility and enrollment requirements; and, funding allocation.

What Does the PCIP Mean For You?

The PCIP program may be able to help you, if you've been locked out of the insurance market, with a temporary program that will be in place until 2014. In 2014, all Americans will have access to affordable health insurance choices, either through their employer, or through a new competitive marketplace called an Exchange, where insurance companies will no longer be allowed to discriminate based on your medical condition.

The PCIP will be available in every state—but the program will vary depending on your state. Many States run programs – often called "high risk pools" – to offer insurance to people who have a pre-existing condition. To build on that leadership, States can choose to run this new program with resources made available by Congress under the Affordable Care Act. HHS, with the help of the U.S. Office of Personnel Management and the U.S. Department of Agriculture's National Finance Center, will run a PCIP in States that choose not to do so themselves. As of today, 28 States and the District of Columbia have proposed to operate PCIP programs using Federal dollars and 22 States have chosen to allow HHS to operate the program for their residents. The Federal government has contracted with a national insurance plan to administer benefits in those 22 states.

The program:

- Will cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. All covered benefits are available to you, even to treat a pre-existing condition.
- Won't charge you a higher premium just because of your medical condition.
- Doesn't base eligibility on income.

Eligibility

There are a few requirements to meet before you can enroll in the PCIP program – regardless of whether your program is run by your State or Federal government. Applicants must:

- Be a citizen or national of the United States or lawfully present in the United States.
- Have been uninsured for at least the last six months.
- Have had a problem getting insurance due to a pre-existing condition.

Different States may use different methods of determining whether you have a pre-existing condition and whether you have been denied insurance coverage. Specifically, a PCIP may determine that you have a pre-existing condition based on providing documented evidence that you meet any one or more of the following criteria:

- An insurer has refused, or has provided clear indication that it would refuse, to issue you coverage based on your health;
- You been offered individual coverage but only with a rider that excludes coverage of benefits associated with your pre-existing condition; or
- You have a medical or health condition specified by the State and approved by the Secretary of HHS.
- You satisfy another test applied by a State with the approval of HHS.

These criteria vary by State, so you need to check on how to establish eligibility in your state. For a list of State programs go to www.healthcare.gov, the comprehensive website and portal for the Affordable Care Act.

Benefits

The PCIP program will cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. All covered benefits are available for you, even to treat a pre-

existing condition. The regulation specifies the required benefits that all PCIPs must cover. This list builds off of the essential health benefits as enacted in the Affordable Care Act, as well as the most commonly covered services offered in existing State high risk pools, and the benefits offered to Members of Congress and other government workers by the Federal Employees Health Benefits Plan (FEHBP). Required benefits include:

- Hospital inpatient services
- Hospital outpatient services
- Mental health and substance abuse services
- Professional services for the diagnosis or treatment of injury, illness, or condition
- Non-custodial skilled nursing services
- Home health services
- Durable medical equipment and supplies
- Diagnostic x-rays and laboratory tests
- Physical therapy services (occupational therapy, physical therapy, speech therapy)
- Hospice care
- Emergency services, and ambulance services
- Prescription drugs
- Preventive care
- Maternity care

The regulation also spells out which services where providing coverage is unequivocally prohibited which parallels the list of excluded services in the FEHBP. Specifically excluded services include:

- Cosmetic surgery or other treatment for cosmetic purposes except to restore bodily function or correct deformity resulting from disease.
- Custodial care except for hospice care associated with the palliation of terminal illness.
- In vitro fertilization, artificial insemination or any other artificial means used to cause pregnancy.
- Abortion services except when the life of the woman would be endangered or when the pregnancy is the result of an act of rape or incest.
- Experimental care except as part of an FDA-approved clinical trial.

Premium Rates

Premiums will vary depending on the State in which you live. (But, as an example, if you live in a State where the U.S. Department of Health and Human Services provides coverage, the premium for a 50 year old enrollee may range between $320 and $680). For an estimated premium range for your State, please visit, www.HealthCare.gov.