FOR GROUPS 2–50
FOR GROUPS OF 51+
INDIVIDUAL & FAMILY PLANS

BROKER GUIDE TO HEALTH CARE REFORM

January 2011

Inside:

- Understanding grandfathered status
- Benefit rule changes
- Preventive services summary
- Key provision details (over-age dependent age, no pre-existing for children and more)

Health Net®
A BETTER DECISION

HEALTH CARE REFORM: WHERE ARE WE NOW

The Affordable Care Act (ACA) is bringing numerous changes to the health insurance and health care worlds. Health Net is ready for the changes, but we realize that many people still have questions about how health care reform impacts their plan coverage.

We created this guide to give you a detailed resource for sharing information as you work with clients and help them make the decisions that are best for their health, business and budget.

As always, your Health Net sales representative is here to support you and your business. Also take a look at www.healthnet.com/broker (choose your region and then Forms and Brochures), for our latest resources.

Count on Health Net for everything you need to consult with your clients and ensure continued sales success.

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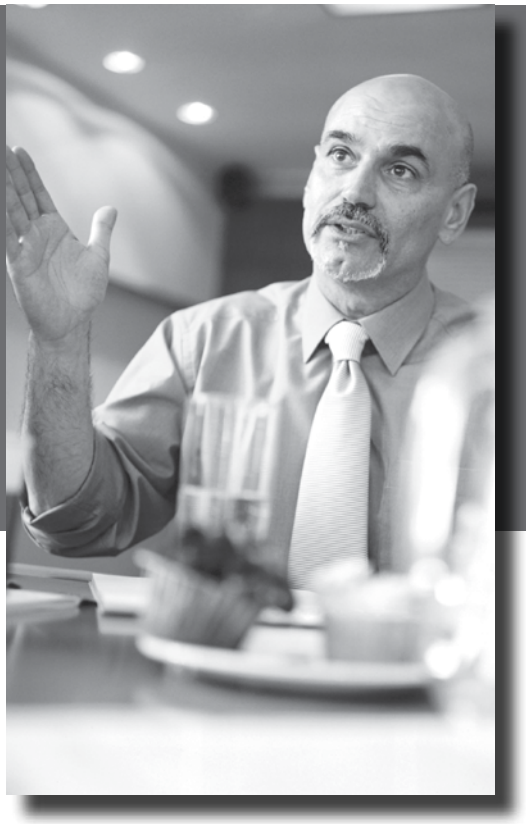

CHAPTER 1

ABOUT GRANDFATHERED PLAN STATUS

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A grandfathered plan is a group or individual health plan in which a person was enrolled on or before March 23, 2010 and that has not been significantly changed. These plans are exempt from *certain* health care reform provisions.

Generally, grandfathered health plans may make routine changes to their policies and maintain grandfathered status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with state or other federal laws.

Many plan changes, including an increase of 5 percentage points or more in employees' medical premium contribution rates (since March 23, 2010) or changes in health insurance carriers, may cause plans to lose grandfathered status. When a plan loses grandfathered status, it must comply with some additional health care reform changes.

For more details on what types of changes a plan can make without losing grandfathered status and which changes will trigger status loss, please see these documents on our website:

- Health Care Reform Q&A
- Questions to Help Determine Grandfathered Plan Status

Just go to www.healthnet.com/broker. Choose your region and then *Forms and Brochures*.

CHAPTER 2

HEALTH CARE REFORM PROVISIONS FOR GRANDFATHERED AND NON-GRANDFATHERED PLANS

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The following side-by-side comparison shows how the health care reform mandates differ between grandfathered and non-grandfathered plans by type and size of plan. Note that "essential health benefits" and "restricted" annual limits are still pending federal definition.

To make it easy to distinguish between plans that have grandfathered status and those that do not, Health Net plan overviews in California will now feature one of two description codes:

GF: Grandfathered plans **NG: Non-grandfathered plans**

Individual & Family Plan (IFP)

	NON-GRANDFATHERED PLANS	GRANDFATHERED PLANS
Note: Provisions on gray backgound apply to both grandfathered and non-grandfathered plans.		
Lifetime limits *(Effective 2010)*	No lifetime limits on "essential health benefits"	
Rescissions *(Effective 2010)*	Limits conditions under which insurers may rescind coverage after it has been issued	
Dependent coverage *(Effective 2010)*	Extension of dependent coverage to age 26	
Medical Loss Ratio (MLR) reporting *(Effective 2010)*	Plans must conform to an 80 percent MLR or pay rebates to the enrollees if they fail to meet the requirement.	
Annual limits *(Effective 2010)*	"Restricted" annual limits on the value of "essential health benefits" *(Annual limits for "essential health benefits" are prohibited as of 1/1/14.)*	Not applicable to grandfathered plans
No pre-existing conditions exclusion for children *(Effective 2010)*	Plans may not impose exclusions for children under age 19 with pre-existing conditions.	Not applicable to grandfathered plans
Preventive services *(Effective 2010)*	Plans must cover, without cost-sharing, certain preventive services.[1]	Not applicable to grandfathered plans
Emergency services *(Effective 2010)*	Plans covering emergency services must meet certain standards, e.g., not requiring prior authorization, covering services from non-participating providers, out-of-network cost-sharing not to exceed in-network rates, etc.	Not applicable to grandfathered plans
Internal/external appeals *(Effective 2010)*	Plans must provide internal process for appeals of coverage as well as give notice of external process for appeals of coverage.	Not applicable to grandfathered plans
Any willing participating provider *(Effective 2010)*	Plans must allow members to designate their own PCPs, OB/GYNs and pediatricians.	Not applicable to grandfathered plans

[1]As determined by organizations such as the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention.

Individual & Family Plan (IFP) *(continued)*

	NON-GRANDFATHERED PLANS	GRANDFATHERED PLANS
Note: Provisions on gray backgound apply to both grandfathered and non-grandfathered plans.		
Uniform explanations and standardized definitions *(Effective 2012)*	Plans must use uniform explanation of coverage documents and standardized definitions as determined by Health and Human Services (HHS).	
No pre-existing condition exclusions *(Effective 2014)*	Plans may not impose exclusions for pre-existing conditions (no age requirement).	Not applicable to grandfathered plans
Prohibition of use of health status *(Effective 2014)*	Plans may not establish rules for eligibility based on health status, medical conditions, claims experience, disability – any health-related factor as determined by HHS.	Not applicable to grandfathered plans
Risk-adjustment program *(Effective 2014)*	States will implement a risk-adjustment program based on federal standards that assesses a charge on issuers whose actual risk for a year is less than average, and pays issuers with actual risk for a year that is greater than the average.	Grandfathered plans will not participate in the program.
Guaranteed issue/availability of coverage *(Effective 2014)*	Plans must accept any individual who applies for coverage. (Insurer may restrict enrollment to open/special enrollment periods.)	Not applicable to grandfathered plans
Guaranteed renewability of coverage *(Effective 2014)*	Plans must renew coverage or continue it in force at the option of the individual.	Not applicable to grandfathered plans
Rating rules *(Effective 2014)*	Plans must adhere to rating rules where premiums may vary only by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Geography (defined by the state/ approved by HHS)	Not applicable to grandfathered plans
Essential health benefits package *(Effective 2014)*	All plans must include the "essential health benefits" package	Not applicable to grandfathered plans
Clinical trials *(Effective 2014)*	Plans may not deny, limit or impose additional conditions for coverage of routine patient costs associated with approved clinical trials.	Not applicable to grandfathered plans
Personal coverage requirement *(Effective 2014)*	U.S. citizens and legal residents must purchase coverage or face a penalty (unless otherwise exempt from this mandate).	

Small Business Group (2–50 employees)

	NON-GRANDFATHERED PLANS	GRANDFATHERED PLANS
Note: Provisions on gray backgound apply to both grandfathered and non-grandfathered plans.		
Lifetime limits *(Effective 2010)*	No lifetime limits on "essential health benefits"	
Annual limits *(Effective 2010)*	"Restricted" annual limits on the value of "essential health benefits" *(Annual limits for "essential health benefits" are prohibited as of 1/1/14.)*	
Recissions *(Effective 2010)*	Limits conditions under which insurers may rescind coverage after it has been issued	
Dependent coverage *(Effective 2010)*	Extension of dependent coverage to age 26	
No pre-existing conditions exclusion for children *(Effective 2010)*	Plans may not impose exclusions for children under age 19 with pre-existing conditions.	
Medical Loss Ratio (MLR) reporting *(Effective 2010)*	Plans must conform to an 80 percent MLR or pay rebates to the enrollees if they fail to meet the requirement.	
Preventive services *(Effective 2010)*	Plans must cover, without cost-sharing, certain preventive services.[2]	Not applicable to grandfathered plans
Emergency services *(Effective 2010)*	Plans covering emergency services must meet certain standards, e.g., not requiring prior authorization, covering services from nonparticipating providers, out-of-network cost-sharing not to exceed in-network rates, etc.	Not applicable to grandfathered plans
Internal/external appeals *(Effective 2010)*	Plans must provide internal process for appeals of coverage as well as give notice of external process for appeals of coverage.	Not applicable to grandfathered plans
Any willing participating provider *(Effective 2010)*	Plans must allow members to designate their own PCPs, OB/GYNs and pediatricians.	Not applicable to grandfathered plans
Nondiscrimination based on salary *(Effective 2010)*	Plans may not discriminate in favor of highly compensated individuals.	Not applicable to grandfathered plans
Uniform explanations and standardized definitions *(Effective 2012)*	Plans must use uniform explanation of coverage documents and standardized definitions as determined by Health and Human Services (HHS).	
No pre-existing condition exclusions *(Effective 2014)*	Plans may not impose exclusions for pre-existing conditions (no age requirement).	
No excessive waiting periods *(Effective 2014)*	Plans may not apply a waiting period that exceeds 90 days.	
Prohibition of use of health status *(Effective 2014)*	Plans may not establish rules for eligibility based on health status, medical conditions, claims experience, disability – any health-related factor as determined by HHS.	Not applicable to grandfathered plans

[2]As determined by organizations such as the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention.

Small Business Group (2–50 employees) *(continued)*

	NON-GRANDFATHERED PLANS	GRANDFATHERED PLANS
Note: Provisions on gray backgound apply to both grandfathered and non-grandfathered plans.		
Risk-adjustment program *(Effective 2014)*	States will implement a risk-adjustment program based on federal standards that assesses a charge on issuers whose actual risk for a year is less than average, and pays issuers with actual risk for a year that is greater than the average.	Grandfathered plans will not participate in the program.
Guaranteed issue/availability of coverage *(Effective 2014)*	Plans must accept every employer who applies for coverage. (Insurers may restrict enrollment to open/ special enrollment periods.)	Not applicable to grandfathered plans
Guaranteed renewability of coverage *(Effective 2014)*	Plans must renew coverage or continue it in force at the option of the plan sponsor.	Not applicable to grandfathered plans
Rating rules *(Effective 2014)*	Plans must adhere to rating rules where premiums may vary only by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Family composition • Geography (defined by the state/ approved by HHS)	Not applicable to grandfathered plans
Small business tax credit *(Effective 2014)*	Provides a tax credit for qualified small employers to purchase health insurance for employees in a Health Insurance Exchange.	Not applicable to grandfathered plans
Essential health benefits package *(Effective 2014)*	All plans must include the "essential health benefits" package and must comply with limitations on annual cost-sharing.	Not applicable to grandfathered plans
Nondiscrimination in health care *(Effective 2014)*	Plans must not discriminate against employers based upon receiving subsidies or cooperating with investigations of the Fair Labor Standards Act.	Not applicable to grandfathered plans
Clinical trials *(Effective 2014)*	Plans may not deny, limit or impose additional conditions for coverage of routine patient costs associated with approved clinical trials.	Not applicable to grandfathered plans

Mid-size and Large Group (51+ employees)

	NON-GRANDFATHERED PLANS	GRANDFATHERED PLANS
Note: Provisions on gray backgound apply to both grandfathered and non-grandfathered plans.		
Lifetime limits *(Effective 2010)*	No lifetime limits on "essential health benefits"	
Annual limits *(Effective 2010)*	"Restricted" annual limits on the value of "essential health benefits" *(Annual limits for "essential health benefits" are prohibited as of 1/1/14.)*	
Recissions *(Effective 2010)*	Limits conditions under which insurers may rescind coverage after it has been issued	
Dependent coverage *(Effective 2010)*	Extension of dependent coverage to age 26	
No pre-existing conditions exclusion for children *(Effective 2010)*	Plans may not impose exclusions for children under age 19 with pre-existing conditions.	
Medical Loss Ratio (MLR) reporting *(Effective 2010)*	Plans must conform to an 85 percent MLR or pay rebates to the enrollees if they fail to meet the requirement.	
Preventive services *(Effective 2010)*	Plans must cover, without cost-sharing, certain preventive services.[3]	Not applicable to grandfathered plans
Emergency services *(Effective 2010)*	Plans covering emergency services must meet certain standards, e.g., not requiring prior authorization, covering services from nonparticipating providers, out-of-network cost-sharing not to exceed in-network rates, etc.	Not applicable to grandfathered plans
Internal/external appeals *(Effective 2010)*	Plans must provide internal process for appeals of coverage as well as give notice of external process for appeals of coverage.	Not applicable to grandfathered plans
Any willing participating provider *(Effective 2010)*	Plans must allow members to designate their own PCPs, OB/GYNs and pediatricians.	Not applicable to grandfathered plans
Nondiscrimination based on salary *(Effective 2010)*	Plans may not discriminate in favor of highly compensated individuals.	Not applicable to grandfathered plans
Uniform explanations and standardized definitions *(Effective 2012)*	Plans must use uniform explanation of coverage documents and standardized definitions as determined by Health and Human Services (HHS).	
No pre-existing condition exclusions *(Effective 2014)*	Plans may not impose exclusions for pre-existing conditions (no age requirement).	
No excessive waiting periods *(Effective 2014)*	Plans may not apply a waiting period that exceeds 90 days.	
Prohibition of use of health status *(Effective 2014)*	Plans may not establish rules for eligibility based on health status, medical conditions, claims experience, disability – any health-related factor as determined by HHS.	Not applicable to grandfathered plans

[3]As determined by organizations such as the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention.

Mid-size and Large Group (51+ employees) *(continued)*

	NON-GRANDFATHERED PLANS	GRANDFATHERED PLANS
Note: Provisions on gray backgound apply to both grandfathered and non-grandfathered plans.		
Guaranteed issue/availability of coverage *(Effective 2014)*	Plans must accept every employer who applies for coverage. (Insurers may restrict enrollment to open/ special enrollment periods.)	Not applicable to grandfathered plans
Guaranteed renewability of coverage *(Effective 2014)*	Plans must renew coverage or continue it in force at the option of the plan sponsor.	Not applicable to grandfathered plans
Rating rules *(Effective 2014)*	(Only applicable to large group plans in states that allow them to purchase through the Exchange.) Plans must adhere to rating rules where premiums may vary only by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Family composition • Geography (defined by the state, approved by HHS)	Not applicable to grandfathered plans
Nondiscrimination in health care *(Effective 2014)*	Plans must not discriminate against employers based upon receiving subsidies or cooperating with investigations of the Fair Labor Standards Act.	Not applicable to grandfathered plans
Clinical trials *(Effective 2014)*	Plans may not deny, limit or impose additional conditions for coverage of routine patient costs associated with approved clinical trials.	Not applicable to grandfathered plans
Employer responsibility requirment *(Effective 2014)*	Large employers (at least 50 employees) must pay a penalty if they do not offer health insurance coverage to employees.	

Self-insured and ASO plans

	NON-GRANDFATHERED PLANS	GRANDFATHERED PLANS
Note: Provisions on gray backgound apply to both grandfathered and non-grandfathered plans.		
Lifetime limits *(Effective 2010)*	No lifetime limits on "essential health benefits"	
Annual limits *(Effective 2010)*	"Restricted" annual limits on the value of "essential health benefits" *(Annual limits for "essential health benefits" are prohibited as of 1/1/14.)*	
Recissions *(Effective 2010)*	Limits conditions under which insurers may rescind coverage after it has been issued	
Dependent coverage *(Effective 2010)*	Extension of dependent coverage to age 26. Prior to 2014, grandfathered plans are only required to extend coverage if the adult dependent does not have access to coverage under an eligible employer-sponsored health plan.	
No pre-existing conditions exclusion for children *(Effective 2010)*	Plans may not impose exclusions for children under age 19 with pre-existing conditions.	
Medical Loss Ratio (MLR) reporting *(Effective 2010)*	No MLR reporting for grandfathered or non-grandfathered plans.	
Preventive services *(Effective 2010)*	Plans must cover, without cost-sharing, certain preventive services.[4]	Not applicable to grandfathered plans
Emergency services *(Effective 2010)*	Plans covering emergency services must meet certain standards, e.g., not requiring prior authorization, covering services from nonparticipating providers, out-of-network cost-sharing not to exceed in-network rates, etc.	Not applicable to grandfathered plans
Internal/external appeals *(Effective 2010)*	Plans must provide internal process for appeals of coverage as well as give notice of external process for appeals of coverage.	Not applicable to grandfathered plans
Any willing participating provider *(Effective 2010)*	Plans must allow members to designate their own PCPs, OB/GYNs and pediatricians.	Not applicable to grandfathered plans
Uniform explanations and standardized definitions *(Effective 2012)*	Plans must use uniform explanation of coverage documents and standardized definitions as determined by Health and Human Services (HHS).	
No pre-existing condition exclusions *(Effective 2014)*	Plans may not impose exclusions for pre-existing conditions (no age requirement).	
No excessive waiting periods *(Effective 2014)*	Plans may not apply a waiting period that exceeds 90 days.	
Prohibition of use of health status *(Effective 2014)*	Plans may not establish rules for eligibility based on health status, medical conditions, claims experience, disability – any health-related factor as determined by HHS.	Not applicable to grandfathered plans

[3]As determined by organizations such as the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention.

Self-insured and ASO plans *(continued)*

	NON-GRANDFATHERED PLANS	GRANDFATHERED PLANS
Note: Provisions on gray backgound apply to both grandfathered and non-grandfathered plans.		
Nondiscrimination in health care *(Effective 2014)*	Plans must not discriminate against employers based upon receiving subsidies or cooperating with investigations of the Fair Labor Standards Act.	Not applicable to grandfathered plans
Clinical trials *(Effective 2014)*	Plans may not deny, limit or impose additional conditions for coverage of routine patient costs associated with approved clinical trials.	Not applicable to grandfathered plans

CHAPTER 3

PREVENTIVE SERVICES DEFINED

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The following preventive services are being covered at $0 cost-share (in-network) on all non-grandfathered plans per the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to the Coverage of Preventive Services under the Affordable Care Act.

1. The United States Preventive Services Task Force (USPSTF) Grade A and B Recommendations:

- Abdominal aortic aneurysm screening: men
- Alcohol misuse counseling
- Anemia screening: pregnant women
- Aspirin to prevent cardiovascular disease: men and women *(see Note 1)*
- Bacteriuria screening: pregnant women
- Blood pressure screening
- BRCA screening, counseling about
- Breast cancer preventive medication *(see Note 2)*
- Breast cancer screening
- Breastfeeding counseling
- Cervical cancer screening
- Chlamydial infection screening: pregnant women, non-pregnant women
- Cholesterol abnormalities screening: men (ages 35 and older, ages 20 to 35)
- Cholesterol abnormalities screening: women (ages 45 and older, ages 20 to 45)
- Colorectal cancer screening
- Dental caries chemoprevention: preschool children
- Depression screening: adolescents and adults
- Diabetes screening
- Folic acid supplementation *(see Note 1)*
- Gonorrhea prophylactic medication: newborns
- Gonorrhea screening: women
- Healthy diet counseling
- Hearing loss screening: newborns
- Hemoglobinopathies screening: newborns
- Hepatitis B screening: pregnant women
- HIV screening
- Hypothyrodism screening: newborns
- Iron supplementation in children *(see Note 1)*
- Osteoporosis screening: women
- Obesity screening and counseling: children, adults
- Phenylketonuria (PKU) screening: newborns
- Rh incompatibility screening: first pregnancy visit, 24–28 weeks gestation
- Sexually transmitted infections counseling
- Tobacco use counseling: pregnant women, non-pregnant adults
- Syphilis screening: pregnant women, non-pregnant persons
- Visual acuity screening in children

Note 1

The guidelines recommend that physicians counsel patients on the use of these over-the-counter medication/ supplements.

Note 2

The guidelines recommend that physicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention.

2. Recommendations of the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention (CDC).

3. Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA) for Infants, Children and Adolescents. Specifically:

   - The Periodicity Schedule of the Bright Futures Recommendations for Pediatric Health Care
   - The Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC)

For more details on Preventive Services, please visit us at www.healthnet.com/broker. Choose your region and then *Forms and Brochures*. From the Forms and Brochures list, select the *Preventive Healthcare Services PDF*.

CHAPTER 4

DETAILS ON KEY MANDATES

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Several health care reform mandates effective in 2010 have garnered much interest. To help you consult with and answer questions from clients, we're providing additional detail on these key mandates.

Over-age dependent coverage

Dependent coverage has been extended to the dependent's 26th birthday for all plan types and sizes.

- The extension applies both to grandfathered and non-grandfathered plans.
- For IFP, the provision applies to dependents of the primary subscriber, subject to underwriting approval.

The regulations require that all plan subscribers (including employees, covered retirees and COBRA participants) receive a written notice of the opportunity to enroll their dependents under this provision. Health plans and employer groups are required to provide a 30-day open enrollment period to allow participants to add their dependents up to age 26 who are not currently on the plan. Coverage for these dependents will be effective on the contract renewal date.

Your clients can use the sample language in the following callout box to notify employees about the changes in over-age dependent coverage.

For use by employers in complying with over-age notification:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26, are eligible to enroll in the *[insert your company name]* group health plan offered through Health Net. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective *[insert date that is the first day of the first plan year beginning on or after September 23, 2010]*. For more information contact the *[employer contact name]* at *[insert contact information]*.

Pre-existing conditions for children under age 19

Effective September 23, 2010, employer group health plans and new individual plans are not allowed to deny or exclude coverage for children under age 19 based on a pre-existing condition including a disability.

Beginning in 2014, most plans won't be allowed to deny or exclude anyone or charge more for a pre-existing condition, including a disability.

Only grandfathered Individual & Family Plan (IFP) policies are exempt from this provision.

Health plans may have an annual open enrollment period for children under age 19 who have pre-existing conditions. Health Net is in the process of establishing Open Enrollment (OE) periods for children under 19. We expect more details in the near future as state and federal regulations and procedures are clarified, and we will update you at that time.

Until the regulations and procedures are clarified and our OE periods begin, we will not be accepting applications for coverage for children under the age of 19. When OE begins, we will commence accepting applications for children under family plans.

This change will not affect:

- Those currently enrolled in child-only plans.
- Those currently enrolled in employer-sponsored plans.
- Those currently enrolled with their parents on a family plan.
- The addition of newborns and adopted children to existing family plans that include child dependent coverage.
- Enrollment of:
  - [California only] "federally eligible" children who meet the requirements for guaranteed issue coverage under the California Insurance Code.
  - [Arizona only] HIPAA-eligible children who meet the requirements for guaranteed issue coverage.
  - [Oregon only] children who meet the requirements for Oregon Portability plans.

Nondiscrimination based on salary

Under the new Public Health Service Act section 2716, non-grandfathered insured plans are required to comply with section 105(h)(3), (4), and (8) of the IRS code of 1986, which provides that a group health plan may not "discriminate," as that term is defined in the code, in favor of "highly compensated employees." If such discrimination occurs, the employer could be subject to an excise tax penalty of $100 per day.

Prior to the Affordable Care Act (ACA) and continuing following passage of the ACA, self-funded plans also are required to comply with IRS code sections which provide that if a self-funded group health plan "discriminates," as that term is defined in the code, in favor of "highly compensated employees," some or all of the value of the payments made by the employer to cover claims for medical services on behalf of the employee will be treated as income to the employee and thus taxable.

Employers will have to determine whether they have a discriminatory plan or not and make the necessary changes. We recommend employers consult with a tax advisor and/or legal counsel for discrimination determinations. Please note that Health Net does not do discrimination testing.

Grandfathered plans are exempt from the nondiscrimination provision.

Small-employer tax credit

One of the reforms to address affordability is the small-employer tax credit.

This tax credit is available to small employers that contribute a minimum of 50 percent of the cost of single coverage. Eligible small businesses can claim the credit starting with 2010 income tax returns that they file in 2011.

The maximum tax credits available begin for the 2010 tax year (and increase for 2014):

- Tax years 2010–2013: Maximum credit is 35 percent of premium paid (25 percent for tax exempt organizations).
- Beginning in Tax Year 2014: Maximum credit is 50 percent of premium (35 percent for tax exempt organizations).

For eligibility rules and examples of how the credit applies to employers in different circumstances, go to the IRS website: http://www.irs.gov/newsroom/article/0,,id=223666,00.html.

Rescissions on health insurance policy

Effective in 2010, the Affordable Care Act limits the circumstances under which insurers may rescind coverage after it has been issued.

Interestingly, in 2007 Health Net became the first health plan in the nation to halt rescissions without third-party review. On April 30, 2010, we publicly reaffirmed this policy. Health Net will only rescind coverage when a member has engaged in fraud or has made intentional misrepresentation of fact in order to obtain insurance.

In addition to halting rescissions, we've also:

- undertaken the extensive processes of ensuring our applications and underwriting processes are clear and understandable, and we obtain all necessary information before issuing a policy; and
- implemented heightened broker reviews, training and education.

These are just some of the ways we're already aligned with federal reform efforts to protect the health and coverage needs of the people we serve.

Health Net recommends that, before making any new health care coverage decisions, employer groups consult with their legal counsel and/or tax advisors to determine the best approach for their company in light of health care reform.

Notes:

Notes: