

## A Look at 2011 Changes

### **Internal Claims and Appeals and External Review**

The Affordable Care Act includes new requirements for internal appeals, as well as an external review process for non-grandfathered plans that began on or after Sept. 23, 2010. The Internal Revenue Service, U.S. Department of Labor (DOL) and HHS published an interim final rule in July 2010 regarding specific standards for internal and external claims and appeal processes and an amendment to the interim final rule on June 24, 2011.

### **Internal Claims and Appeals:**

All non-grandfathered group health plans, including fully-insured and self-insured plans, are required to comply with all regulations applicable under the current DOL claims procedures, including new standards for providing notices to members in a culturally and linguistically appropriate manner. In addition, a notice of an adverse benefit determination must include additional criteria, such as the date of service, identity of the healthcare provider, and claim amount, if applicable. Upon request, sponsors also must provide diagnosis and treatment codes (and their meanings).

Additional requirements include:

- A full and fair review
- Explanation of coverage rescission
- Potential conflicts of interest oversight

### **External Review:**

The healthcare reform law requires that an external review process be available for any claim involving medical judgment when all internal claims and appeals processes have been exhausted. This excludes claims involving only contractual or legal interpretation resolved without any use of medical judgment. The determination of whether a decision or rescission of coverage involved use of medical judgment is made by the external reviewer. The new rule became effective for plan years beginning on or after Jan. 1, 2011. Fully-insured plans that are subject to a state external review process may continue to follow that process until further guidance is released on the federal external review process. Plans not already subject to a state review process must follow the new federal process.

### **Preventive Services**

New regulations regarding preventive services are covered under guidance published in the Federal Register on July 19, 2010. The rules require health plans to cover recommended preventive services without charging a copayment, coinsurance or deductible. However, plans can limit preventive service to in-network providers or access within a particular benefit only, such as the medical benefit. The plan insurer is required to provide all enrollees a 60-day advance notice before any material modification to coverage or cost-sharing becomes effective.

### **Medical Loss Ratio**

HHS published new regulations in the Federal Register on Dec. 1, 2010, which, along with additional technical guidance issued on May 13, outline new requirements for fully-insured plans to report costs for the purpose of calculating insurers' MLR — the portion of insurance premium dollars spent on reimbursement for direct clinical services provided to enrollees (incurred claims) and activities to improve healthcare quality divided by the insurer's premium revenue minus federal and state taxes, and licensing and regulatory fees. In general, 'healthcare quality' refers to activities that improve health

outcomes, and are grounded in evidence-based medicine. Large group insurers must spend at least 85% of healthcare premiums on claims and activities to improve health care quality, and individual and small group insurers, a minimum of 80%. Insurers must report their MLR to HHS beginning June 1, 2012, based on 2011 data. Each insurer must aggregate MLR by state and market segment (small, large, individual), and report annually to HHS. Plans that fail to meet the MLR standard for a given year are required to provide rebates to enrollees beginning in August 2012. The amount of the rebate will be determined by the difference between the required and actual MLR.

### **FSA/HSA/HRA Changes**

Beginning Jan. 1, 2011, many over-the-counter (OTC) medications are no longer eligible for reimbursement through an HRA, FSA or HSA unless accompanied by a letter of medical necessity or doctor's directive. The OTC limitation is on medication only. Other OTC items such as bandages and contact lens solution are still eligible. Beginning this year, the excise tax for non-qualified HSA withdrawals doubles to 20%. Beginning Jan. 1, 2013, employee contributions to health FSAs will be limited to \$2,500 per year, with future increases to allow for inflation.

## **2010: A Look Back at Initial Healthcare Reform Changes**

### **Client Support for Changes Effective Sept. 23, 2010**

Many of the regulation changes released under the Affordable Care Act on March 23, 2010 became effective September 23, 2010. About 86% of plan sponsors affected by the reform provisions were able to make immediate changes to their benefit plans.

### **Grandfathering**

Grandfathered status was available to plans in existence on March 23, 2010, when healthcare reform became law. Medicare or retiree-only plans were not impacted by this rule. Insured collectively bargained plans will retain grandfather status, even if changes are made, until the collective bargaining agreement in effect on March 23, 2010 terminates. Plans can make some limited modifications without losing their grandfathered status – including premium increases of less than 5%, changes required by federal or state law, changes that increase benefits and changes by third party administrators, including pharmacy benefit managers (PBMs). The rule didn't indicate whether changes to formularies, network providers, home delivery programs or utilization management programs can be made without affecting grandfathered status. Changes that cause the loss of grandfathered status include:

- Elimination of all benefits for a particular condition
- Coinsurance increases
- Increase in deductibles or copayments greater than the amount allowed
- Decreasing employer contribution rate or annual/lifetime limits by more than allowable amounts.

Grandfathered plans are not required to comply with the Preventive Services or Appeals rules.

### **Lifetime and Annual Limit Prohibitions**

Regulations published in the Federal Register on June 28, 2010 provide guidance and clarification regarding new restrictions on imposing lifetime or annual limits on the dollar value of health benefits. Group and individual health plans (both fully-funded and self-funded) are generally prohibited from imposing annual or lifetime limits on the dollar value of "essential health benefits" for plan years beginning on or after Sept. 23, 2010. However, the government has not yet defined what constitutes essential health benefits. This applies to all plans in all market segments, new or grandfathered.

Grandfathered plans may impose restricted annual limits until Jan. 1, 2014, after which there will be a three-year phase-out.

The lowest annual limits allowed are:

- \$750,000 from Sept. 23, 2010 to Sept. 22, 2011
- \$1.25 million from Sept. 23, 2011 to Sept. 22, 2012
- \$2 million from Sept. 23, 2012 to Dec. 31, 2013

### **Coverage for Dependents up to age 26**

Under regulations published in the Federal Register on May 13, 2010, all covered plans that offer dependent coverage must offer coverage to an enrollee's adult children, whether married or unmarried, until age 26. The rule does not apply to grandfathered plans, until Jan. 1, 2014, if the adult child is eligible to enroll in an employer-sponsored health plan.

### **Prohibition on Denied Coverage for Pre-Existing Conditions**

Plans are prohibited from denying coverage to children 18 and younger based on pre-existing conditions, according to regulations published in the Federal Register on June 28, 2010. This protection applies to all types of plans except grandfathered individual policies and will be extended to Americans of all ages beginning in 2014.