How 2010 changes may impact you

Health Care Reform

With the passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010, the nation is moving closer to providing all Americans with access to health care coverage. The new health care reform law includes numerous individual and group comprehensive, major medical insurance market reform provisions that, for the most part, take effect in 2014 or later. Other provisions that are more in line with mandated benefits changes, rather than comprehensive reform, became effective September 23, 2010.

Aetna is committed to compliance with the new legislation, and we are fulfilling our obligation to implement new benefits and health plan requirements. We are now focused on helping all of our constituents better understand how the health care coverage landscape has changed and how we can help them navigate a course forward. A brief description of some of the 2010 changes and their impact follows.

**The following information should be considered a high-level summary. This should not be considered legal or compliance guidance.*

Lifetime limits

Lifetime limits on the dollar value of essential benefits are now prohibited. This provision clarifies that nothing restricts the use of lifetime dollar limits for covered benefits that are not essential benefits.

[Section 2711 of H.R. 3590/Section 2301 of H.R. 4872]

Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

- We will remove lifetime dollar limits from all plans, upon the next effective date or renewal date on or after September 23, 2010.
- We have made a good faith effort in developing our reasonable interpretation of essential benefits, until additional information is provided.
- We will provide plan sponsors with our interpretation of essential benefits. We recommend self-insured plan sponsors seek advice of their own counsel regarding compliance and will consider administration of customer variations that we determine are reasonable.

Annual maximums

Annual dollar limits are prohibited, except it allows for "restricted" annual dollar limits for essential benefits for plan years beginning prior to January 1, 2014. The regulations allow gradually increasing annual limits ($750,000 for plan year 2011; $1.25 million for plan year 2012; and $2 million for plan year 2013) until the limits are eliminated completely in 2014. It also clarifies that nothing restricts the use of annual dollar limits for covered benefits that are not essential benefits.

[Section 2711 of H.R. 3590/Section 2301 of H.R. 4872]

Grandfathered Plans

Individual	No
Insured Group	Yes
Self-Funded Group	Yes

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

- We will remove annual dollar limits for all plans at the plan level upon next effective date or renewal date, on or after September 23, 2010. We will also remove annual dollar limits from all essential benefits.
- We do not have system capability to support restricted annual limits for essential benefits.
- HHS has agreed to waive the restricted annual benefit limit provisions in PPACA for qualified limited benefits plans until 2014. Aetna received a waiver for all SRC limited benefits products for one year.

Rescissions and cancellations of coverage

Rescissions are prohibited, except for fraud or intentional misrepresentation of material fact. It requires prior notice to the enrollee for cancellations.

[Section 2712 of H.R. 3590/Section 2301 of H.R. 4872]

Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

For Individual, Aetna is already in compliance with these regulations. For group plans, Aetna will support plan sponsors to ensure notices are sent to members, where necessary. However, PPACA's Grievance and Appeals provisions require that rescissions are considered adverse determinations, so the process for appeals will be applied.

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Preventive Services

Coverage of specified preventive care is required of non-grandfathered plans without cost sharing (deductibles, copayments, coinsurance, etc.), when provided in network. Preventive care is defined as items or services with an A or B rating by the U.S. Preventive Services Task Force, immunizations recommended by the CDC, preventive care and screenings for infants, children and adolescents supported by HRSA, and screenings for women supported by HRSA. Other preventive services may be covered beyond what is included in the recommendations, and those services may be subject to cost sharing.

[Section 2713 of H.R. 3590]

Grandfathered Plans

Individual	No
Insured Group	No
Self-Funded Group	No

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

- Aetna has developed a list of covered preventive services and will cover them without cost sharing in all insured plans on renewal or effective date on or after Sept. 23, 2010 (except grandfathered plans).
- We will provide our self-funded plan sponsors with this list of services but recommend that they seek the advice of their own counsel regarding compliance.
- We have provided account teams with information they can share with plan sponsors, including a member communication detailing the covered services.
- We are providing doctors in our networks with information to help make sure they know about our preventive care coverage.

Extension of dependent coverage

Plans that offer coverage to children on their parents' plan are required to make coverage available until the adult child reaches the age of 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. It clarifies that nothing requires coverage for the children of dependent children.

[Section 2714 of H.R. 3590/Section 2301 of H.R. 4872]

Grandfathered Plans

Individual	Yes
Insured Group*	Yes
Self-Funded Group*	Yes

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

*Until 2014, not required for dependents who are eligible for other employer coverage

What Aetna is doing

- We are implementing this change for all plans upon renewal or effective date, on or after September 23, 2010.
- For insured plans, we will continue to comply with state laws that require coverage beyond age 26.
- We are providing notices in enrollment kits (as well as through other communication streams) that dependent children whose coverage ended, or were denied coverage, before turning 26 are eligible to enroll in their parents' plan. Individuals may request enrollment for such children for 30 days from the date of notice.

Appeals process

Plans are required to have an internal appeals process that allows enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. Notices of Adverse Determination must include additional elements. Notice of the appeals process is required to be provided to enrollees in a culturally and linguistically appropriate manner. Plans must also have an external review process. Some of the key requirements include a limit of one level of appeal for individual plans, and a required turnaround time for an initial determination on urgent care claims of 24 hours.

[Section 2719 of H.R. 3590]

Grandfathered Plans

Individual	No
Insured Group	No
Self-Funded Group	No

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

- We are working on updates to our processes to bring our plans into compliance with each of the above requirements. A good faith enforcement grace period was granted through July 1, 2011 for certain requirements.
- We have undertaken a systems project to bring us into compliance with the requirement that plans include additional information on explanation of benefits statements.
- We are working with our language vendor to develop a compliant process to identify language needs and provide information in a culturally and linguistically appropriate manner.
- We are working to expand the availability of the external review process beyond its current limits. Self-funded plans can obtain this service through Aetna or they can secure it on their own.

Emergency services

Plans that cover emergency services are required to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level. The regulations require that plans or issuers not seek pre-authorization or pre-certification for emergency services. Notification requirements are permitted. There is also a new payment methodology for emergency services performed out of network; however, this is not applicable if plan/issuer is contractually responsible for balanced billed amounts or where a state law prohibits balance billing so long as clear notice is provided to members regarding lack of financial responsibility.

[Section 2719A of H.R. 3590]

Grandfathered Plans

Individual	No
Insured Group	No
Self-Funded Group	No

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

- Aetna already applies an in-network cost share to emergency services and does not require pre-authorization for such services.
- We are expanding our "hold the member harmless" approach to our Traditional Choice and Open Choice plans, the only plans for which it was not previously in effect. This means that if members receive balance bills, for cost share amounts from non-participating providers for emergency services, we will review and members will not be held responsible for the difference.
- To facilitate this approach, we are making our EOB messaging clearer, and we are developing appropriate language for plan documents.

Access to PCPs and pediatricians

If a plan requires or provides for the designation of a participating primary care provider (PCP), the law mandates the enrollee be permitted to designate any PCP or participating pediatrician for the dependent child.

[Section 2719A of H.R. 3590]

Grandfathered Plans

Individual	No
Insured Group	No
Self-Funded Group	No

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

For most plans, Aetna already is in compliance with these regulations. No changes are required at this time.

Access to Ob/Gyns

Authorization or referral requirements are prohibited for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.

[Section 2719A of H.R. 3590]

Grandfathered Plans

Individual	No
Insured Group	No
Self-Funded Group	No

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

For most plans, Aetna already is in compliance with these regulations. No changes are required at this time.

Prohibition on pre-existing condition exclusions for kids

The imposition of pre-existing condition exclusions for enrollees who are under 19 years of age is prohibited.

[Sections 2704 and 1255 of H.R. 3590/ Section 2301 of H.R. 4872]

Grandfathered Plans

Individual	No
Insured Group	Yes
Self-Funded Group	Yes

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

What Aetna is doing

- We will remove the ability to limit or exclude benefits on this basis for all plans (except grandfathered individual plans), upon the next effective date or next renewal date on or after September 23, 2010.

Uniform coverage documents and standard definitions*

Under PPACA, HHS is required to develop standards for use by group health plans offering group or individual coverage in compiling and providing to enrollees an accurate summary of benefits and explanation of coverage document. These standards must be developed by March 24, 2011 and will include standard definitions of terms used in health insurance coverage. By March 24, 2012, plan sponsors and health insurers must provide to all applicants, enrollees and policyholders a summary of benefits and coverage explanation pursuant to the standards. Failure to do so will result in fines. There is also a 60-day notice requirement when a health plan modifies the terms of the plan or coverage.

[Sections 2715 and 1251 of H.R. 3590]

Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	Yes

Incurred loss/claims reporting requirements*

PPACA requires the submission to the HHS Secretary a report of the ratio of incurred loss (or incurred claims) plus the loss adjustment expense to earned premiums, with respect to each plan year. It provides that the report include the following categories:

1) clinical services provided to enrollees,
2) activities that improve quality, and
3) all other non-claims costs (excluding federal and state taxes and licensing or regulatory fees).

[Sections 2718 and 1251 of H.R. 3590]

Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	No

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	No

Loss ratio standards*

Beginning on January 1, 2011, the law mandates that an annual rebate be provided to each enrollee if the ratio of the amount of premium revenue expended to the total amount of premium revenue is less than:

- 85 percent for large groups
- 80 percent for small group
- 80 percent for individual

The HHS Secretary may adjust the percentage for the individual market if she determines that the application of the 80 percent standard would destabilize the market. Also allows the Secretary to adjust the rates described above if she determines it is appropriate to do so, on account of the volatility of the individual market due to the establishment of State Exchanges. It permits states to establish higher percentages (for all three markets) by regulation.

[Sections 2718 and 1251 of H.R. 3590]

Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	No

Non-Grandfathered Plans

Individual	Yes
Insured Group	Yes
Self-Funded Group	No

*Aetna will be working to implement based on final regulatory direction.

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