Highlights from the IG Living Teleconference, April 22, 2014

Guest Expert: Kris McFalls, manager of reimbursement at CSL Behring, and a previous patient advocate for *IG Living* magazine

This reader teleconference focused on **how changes in healthcare with the enactment of the Affordable Care Act (ACA) gives people with chronic disease a number of new rights**:

• *Grandfathered clauses.* Health insurance plans that are grandfathered under the ACA do not have to follow the changes made by the law. Approximately 38 percent of plans are still grandfathered. Individuals can find out whether their plan is grandfathered by reviewing their plan materials supplied by their insurer or their employer. Or, they can call their insurer to ask.

• *Dependent coverage until age 26.* Dependents can now stay on their parents' insurance plan until age 26. Dependents do not have to be full-time students, they don't have to be claimed on their parents' income tax, they don't have to live with their parents and they can be married (the spouse is not covered, just the child). A caution about this: Even though children can stay on their parents' plans until age 26, health savings accounts cannot be used to pay for care of children between the ages of 24 and 26. This reason for this is the IRS rules are not in coordination with the ACA rules, and the IRS rules trump the ACA.

• *Emergency care fees.* Insurance plans can no longer impose a copayment or co-insurance requirement that is higher than what would be charged for in-network services for emergency care. For instance, in the past, individuals would have to be sure the hospital they went to for emergency care was in network. Under the ACA, individuals can't be charged more for an out-of-network hospital for emergency care than they would be required to pay for in-network care.

• *No restrictions for pre-existing conditions.* Insurance companies can no longer require individuals with a pre-existing condition to wait for insurance, nor can they keep individuals with pre-existing conditions from purchasing insurance. This ACA rule went into effect for children in 2012. As of Jan. 1, 2014, this rule went into effect for group and individual plans for all individuals. The only reason an insurer can deny coverage is if fraud was committed on the application. In addition, plans can't charge a higher rate for those with pre-existing conditions; the only conditions plans can charge a higher rate for is age and smoking status.

• *Expansion of Medicaid.* While the Supreme Court ruled the states could not be compelled under the ACA to expand Medicaid, 27 states and territories have opted to expand Medicaid, and many more are expected to do so. Medicaid expansion increases coverage for individuals who make up to 133 percent of the federal poverty level (FPL). Individuals who live in states that have opted out of Medicaid or who earn more than 133 percent of FPL can apply for state exchange programs.

• *Standardized appeals.* Under the ACA, the right to appeal a reimbursement ruling has now been standardized. Insurers can no longer set their own time limits for appeals. Instead, all plans must reply for requests for urgent care within 72 hours, and preferably within 24 hours. For non-urgent care, insurers have 30 days to reply. For services already rendered, insurers have 60 days to respond. Also under the ACA, an internal and external appeal of urgent cases can be filed at the same time. There are two levels of internal appeals, and the third level is an external appeal. An external appeal is paid for by the insurance company, but it is completely neutral as the external appeal board is not part of the insurance company. The external appeal board consists of experts in the field (such as immunologists) who rule on the case based on the documentation that has been submitted. Therefore, patients can now go straight to the third level if it's an urgent case.

• *Standardized summary of benefits coverage statements.* Previously insurance companies could list on the summary of benefits coverage (SBC) form what they chose to. The ACA has simplified the process by requiring standardized items on the SOB form such as deductible, cost sharing, coinsurance and copayment that must also be defined and placed in a standardized format. This allows patients to compare apples to apples across different plans.

• *State exchanges.* Individuals with pre-existing conditions or high-risk plans can now apply for insurance under the state exchanges that opened up Oct. 1, 2013. Depending upon the state, exchanges operate at either the state or federal level. Either way, all provide the same coverage for the same levels of services: bronze, which pays 60 percent of the cost of care; silver, which pays 70 percent; gold, which pays 80 percent; and platinum, which pays 90 percent. However, there are some states that do not offer platinum level plans. Premiums are based on income level (how much of the FPL individuals make). Individuals who make up to 400 percent of FPL can earn subsidies to help pay for premiums in the form of a tax credit. Those making up to 250 percent of the FPL can earn some assistance in paying out-of-pocket expenses. During open enrollment, individuals are cautioned to ensure they are using the authentic state exchange sites by accessing them through the federal government's website at https://www.healthcare.gov/marketplace/b/welcome. Individuals are also cautioned that many exchange plans have very narrow networks, which means very few providers in the network or physicians who are taking very few patients. These new networks also have preferred provider organizations (PPOs) that will not allow for any out-of-network coverage.

• *Capped combined costs.* Currently, deductibles and copays don't count toward the out-of-pocket maximum for many plans. Under the ACA, they do, and there is only one out-of-pocket maximum. While plans can have a lower out-of-pocket maximum, they can't have one higher than $6,350 for an individual and $12,700 for a family. For the chronically ill with expensive medications, that's still a lot of money, but it's capped. Unfortunately, this rule doesn't start until 2015 because payers and pharmacy benefit managers have not yet upgraded their systems to coordinate the combined costs.

• *Prescription benefit.* Under the ACA, all health plans must have the 10 essential health benefits, one of which is the prescription benefit. So, unless a plan is grandfathered, individuals should have their prescriptions covered. However, plans only have to cover one particular class of a medication. There will likely be more restrictions as payers try to control costs. Therefore, it's possible that the plan could choose to cover one brand of IG over the others.

• *Annual and lifetime caps.* Under the ACA, there are no more lifetime caps on insurance. There are still some annual caps in 2014, but that ends in 2015. Fortunately, the annual cap is very high, so unless individuals have very expensive treatments or procedures, they shouldn't hit their annual cap.

For additional information about patients' rights under the ACA, visit https://www.healthcare.gov/rights-protections-and-the-law/.