HealthPlans
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Compliance Alert
April 15, 2011

Health Care Reform • Member Data Collection • Mass. Minimum Creditable Coverage • State Immunization Programs

Health Care Reform – Non-Grandfathered (NGF) Plans Claims and Appeals Update

Our last Federal Health Care *Compliance Bulletin* – Issue #4 – dated February 7, 2011, indicated that in a future *Bulletin* we would address the provisions of the new Claims and Appeals procedures applicable to non-grandfathered (NGF) plans. These new procedures were scheduled to take effect for plan years beginning on or after July 1, 2011. However, on March 18, 2011, the Department of Labor (DOL) issued new guidance which delays some of these provisions.

Specifically, the following requirements are now delayed until the first plan year that begins on or after January 1, 2012:

- Making determinations regarding urgent care claims within 24 hours (the current standard is 72 hours)
- Providing adverse benefit determinations (EOBs and appeal determination letters) and other plan notices in a non-English language (based on whether a certain proportion of plan participants are literate only in the same non-English language and a specific participant requests the translation)
- Including diagnosis codes, treatment codes and their corresponding meanings on EOBs

The provisions below are not delayed and are still effective on the first plan year that begins on or after July 1, 2011:

- Including specific information in adverse benefit determinations that identifies the claim, date of service, provider, and claim amount (Note: **Health Plans'** EOBs and appeal determination letters are currently in compliance with this provision)
- Including the reasons for denial in adverse benefit determinations (Note: **Health Plans'** EOBs and appeal determination letters are currently in compliance with this provision)
- Providing a description of the available internal appeals and external review processes in adverse benefit determinations (Note: **Health Plans** will be modifying our EOBs and appeal determination letters accordingly to incorporate new model language issued by the DOL)

The following requirements continue to be effective on the first plan year that begins on or after September 23, 2010 (Please see our February 7, 2011 *Compliance Bulletin* for details about these specific requirements)**:**

- Treating rescissions of coverage as adverse benefit determinations
- Expanding the full and fair review requirements in the appeals process
- Providing continued coverage pending the outcome of an appeal
- Providing a third, external review of most claims upon a claimant's request

We will continue to keep you posted as new guidance on all aspects of health care reform is issued.

Outreach for Member Data Required under Medicare Law

Later this month, **Health Plans** will contact medical plan members age 40 and older for whom we have no record of a Social Security Number (SSN). This outreach effort helps meet our obligations as your claims administrator under the Medicare, Medicaid and SCHIP Extension Act of 2007, Section 111 (MMSEA §111).

The member mailing is based on the model forms provided by the Centers for Medicare and Medicaid Services (CMS), and includes an FAQ regarding the data collection and a notice from CMS indicating why providing Medicare or Social Security Numbers is required. We have a dedicated **Health Plans** phone line for this project. Members will be asked to email, call or mail in their SSN information, or call the dedicated line if they have any questions.

Health Plans conducts this outreach effort annually, and provides advance notice about the mailing to our clients each year.

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Massachusetts Minimum Creditable Coverage (MCC) – For plans covering Massachusetts residents

Along with federal health care reform rules, the Massachusetts standards for minimum creditable coverage (MCC) should remain on our clients' radar screens.

All the plans we submitted to the Massachusetts Health Connector Authority in 2009 were certified as providing MCC through 2010. The Connector Authority determined that any plan certified as providing MCC through 2010 is also deemed to provide MCC going forward, ***unless*** the plan is amended to add or increase a deviation from the current MCC standards for coverage. If you request a plan amendment that appears to add or increase a deviation from the standards, we will contact you to discuss whether you would like us to submit your plan to the Connector Authority for certification.

While employers are not required to offer plans that provide MCC, it is important for plans to maintain MCC status since Massachusetts residents age 18 and over must be covered under an MCC compliant plan in order to satisfy the requirements of the individual mandate under Massachusetts law. Each year, **Health Plans** issues 1099-HC forms to Massachusetts plan participants indicating whether or not the plan provided MCC coverage. If a plan does not provide MCC coverage, the plan participants may be subject to a tax penalty up to $1,116, depending on household income.

Immunization Program Assessments – Maine and Vermont

Separately, the states of Maine and Vermont have recently issued regulations that levy surcharges on health plans to help fund the cost of state immunization programs. Currently, the Vermont program is designated as a "pilot" scheduled to run through December 31, 2012, and the Maine program has no end date. The surcharges are based on the estimated costs of the vaccine programs, divided among health plans based on the membership and claims data that plan administrators and insurers, including **Health Plans,** are required to submit to each state on behalf of our clients.

Annually, after surcharges have been determined for the following year, the states will invoice **Health Plans** for payment. We will then apportion the costs among the affected plans (i.e., those with members who reside in those states), and reflect your plan's share of the cost, if any, on your funding request report. The invoice from Vermont is expected within the next several weeks and will be reflected on a subsequent funding request report. The invoice from Maine is not expected until Fall 2011. At that time, we will reflect any applicable apportioned cost on your funding request report. Going forward, we will continue to apportion the invoices we receive to your plan accordingly.

If you have any questions about the information included in this *Alert*, please contact your **Health Plans** Account Manager.

This Alert *is intended to provide a summary of our understanding of significant developments which may affect our clients' plans. It should not be construed as specific legal advice or legal opinion. The contents are for general informational purposes only and are not a substitute for the advice of legal counsel.*