HealthPlans
A HARVARD PILGRIM COMPANY

Compliance Bulletin
September 9, 2011

Federal Health Care Reform
Implementation of Regulations
Issue Number 5:

- **Updated Claims and Appeals Provisions for Non-Grandfathered Plans**
- **Refresher on Measuring Grandfathered Status**
- **Proposed Regulation on Summary of Benefits and Coverage (SBC)**

This is the fifth in a series of *Federal Health Care Reform Compliance Bulletin*s that **Health Plans** is issuing as the provisions of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or health care reform) are implemented, clarified and/or amended.

On June 22, 2011, the Departments of Health and Human Services, Labor and Treasury (the "Agencies"), issued an amendment to the original claims and appeals regulations applicable to non-grandfathered plans, along with technical guidance. These changes amend, ease or clarify portions of the original regulations. This *Bulletin* summarizes the current status of the claims and appeals rules and their applicable effective dates, and updates the *Compliance Bulletin* and *Compliance Alert* we issued on this topic earlier this year.

This Bulletin also includes:

- A refresher on how to measure future plan changes to determine whether they would affect the plan's grandfathered status for those clients whose plans have retained grandfathered status ; and
- Information on the status of the Summary of Benefits and Coverage (SBC) regulations.

Update of Current Claims and Appeals Rules

Important: The Claims and Appeals Rules under the Affordable Care Act *apply only to non-grandfathered plans.* Non-grandfathered plans must comply with both the existing ERISA claims regulations and the new claims and appeals rules. There are no changes to the claims and appeals process for grandfathered plans. Grandfathered plans continue to be subject to the existing ERISA claims regulations.

Provisions Effective for Plan Years Beginning on or after September 23, 2010

This information was initially covered earlier this year in our Compliance Bulletin Issue Number 4 *dated February 7 and a* Compliance Alert *dated April 15.*

Clarifications Regarding Rescissions of Coverage: Plans must treat a rescission of coverage as an adverse benefit determination that is eligible for internal claims appeal and external review. A rescission was defined as any retroactive termination of coverage other than termination due to untimely payment of premiums.

Recent guidance clarifies that retroactive terminations of coverage due to untimely notification from an employee regarding dependent eligibility or due to routine administrative delay in processing terminations of employment (where the employee did not pay for the post-employment coverage) are generally permitted and are not considered rescissions. Plans may rescind coverage only in the event of a member's fraud or intentional misrepresentation of material fact that is relevant to the member's coverage under the plan.

If a plan rescinds coverage, it must provide thirty (30) days advance written notice and include information about the member's right to appeal the termination.

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Update of Current Claims and Appeals Rules
Provisions Effective for Plan Years Beginning on and after September 23, 2010, cont'd

Amendments/Clarifications Regarding External Review: After a final internal appeal determination which results in the continued denial of certain types of claims, plans must provide for an external review by an Independent Review Organization (IRO). If the IRO reverses the denial, the plan must immediately authorize or pay for the services. Please see our *Compliance Bulletin Issue Number 4* for a detailed description of the external review process. Below we summarize the recent changes and clarifications to the external review process:

- *Limited Scope of External Review:* Under the original regulation, all adverse benefit determinations were eligible for external review except for determinations regarding a member's eligibility to participate in the Plan.

  The amended rule limits the scope of external review to adverse benefit determinations involving rescission of coverage or claim denials involving medical judgment. Medical judgment includes denials based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. Denials that only involve contractual or legal interpretation are not eligible for external review (e.g., service never covered under plan; deductible not met; waiting period not satisfied).

  The limited scope rule applies to claims for which external review is requested on or after September 20, 2011. Note: This rule has been designated "temporary", but is expected to remain in place at least until January 1, 2014. The Agencies will provide advance notice if the temporary standard is modified or reverts to the original standard.

- *Implementation of IRO Contracts:* The amended rule allows plans additional time to contract with IROs to perform external reviews: by January 1, 2012, plans (or their administrators) must contract with at least two IROs and by July 1, 2012, they must contract with at least three IROs. The original regulations and guidance required plans to contract with at least 3 IROs. The Agencies later clarified that plans would not be in *per se* violation of the rules if they did not contract with 3 IROs as long as the plan had other steps in place to ensure its external review process was independent and unbiased.

- *Binding Nature of External Review Decision:* The amended rule clarifies that both a plan and a claimant may pursue any applicable legal remedies after the external review process has been completed. However, plans must provide benefits without delay (including making payment for claims) per the IRO's determination, regardless of whether the plan intends to seek judicial review.

- *Strict Adherence Rule Eased:* The original regulation allowed claimants to bypass the internal appeals process and either go directly to external review or seek legal remedies if the plan did not "strictly adhere" to the claims and appeals rules. The amended rule changes the "strict adherence" standard to a "substantial compliance" standard. Now claimants are required to exhaust the internal appeals process before going to external review or seeking legal remedies if the plan's violation of the claims and appeals rules is based on minor compliance errors which are non-prejudicial to the claimant, were beyond the plan's control, and are not reflective of a pattern or practice of non-compliance by the plan. This new standard is similar to the ERISA claims regulations which do not generally permit a claimant to bypass the plan's internal review procedures and file suit when the plan commits minor, inadvertent deviations from the requirements of the regulations.

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Note: Plans are granted an enforcement safe harbor period to implement this substantial compliance rule until plan years beginning on or after January 1, 2012. This means that during the safe harbor period, claimants will need to exhaust the internal claims and appeal process in accordance with the ERISA claims regulations before they can go directly to external review or seek legal remedies.

Urgent Care Timeframe Restored: The original regulation reduced the timeframe for plans to respond to an initial request for approval of an urgent care claim from 72 hours to 24 hours. The amended rule restores the original ERISA standard: plans must respond to a request for approval of an urgent care claim as soon as possible, taking into account the medical exigencies, but no more than 72 hours after the request is received.

The recent Amendment and Technical Guidance have not changed the following requirements which were described in our Compliance Bulletin Issue Number 4*:*

Full and Fair Review: Plans must automatically provide a claimant (free of charge) with any:

a) New or additional evidence considered in connection with the claim as part of the appeals process; and
b) New or additional rationale that would be used to deny the appeal.

This information must be provided as soon as possible and sufficiently in advance of the deadline for making a determination on appeal so that the claimant has reasonable time to respond before the determination deadline. (Under the ERISA claims regulations, plans are required to provide this information only upon the claimant's request.)

Continued Coverage During Appeals Process: Plans must continue coverage during the appeal process, pending the outcome of the review. However, it appears that this requirement is intended to be consistent with the ERISA claim regulations for claims involving concurrent care only: When an ongoing course of treatment has been approved for a specified period of time or number of treatments, plans cannot reduce the period/number without first providing the claimant with advance notice and the opportunity to appeal. Otherwise, there appears to be no requirement to continue coverage while the appeal process is underway.

Provisions Effective for Plan Years Beginning on or after January 1, 2012

Notice Requirements

- **Culturally and Linguistically Appropriate Notice Standards Changed:** The original regulation contained language translation requirements for EOBs and internal appeal determination notices which were based on the make-up of each group health plan, determined by the number of participants in the plan and the percentage of those participants who were literate only in the same non-English language. If the threshold was met:
    a) English versions of notices had to contain a statement in the non-English language offering the notice in the non-English language;
    b) All subsequent notices to any claimant requesting translation would automatically have to be translated; and
    c) Customer assistance would have to provide non-English assistance with filing claims and appeals.

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The amended rule changes the language translation requirements to a standard that is based on the make-up of the population where the claimant resides. It requires plans to include a non-English statement on the notices regarding language assistance services in cases where 10% or more of the population in the claimant's county are literate only in the same non-English language (as determined by Federal census data). The list of counties that fit these criteria was issued with the amended rule and includes counties only where the following languages are spoken: Spanish, Navajo, Chinese and Tagalog (Filipino). The census data will be updated periodically (but no more than annually). Plans subject to the language requirements need to provide a telephone hotline to answer questions and provide help with filing claims and appeals. If translation of a notice is requested by the claimant who resides in one of the counties affected, plans only need to translate that specific notice and are not required to automatically translate all future notices.

Note: Under the current county census list, this special notice requirement is not applicable to residents of any county in any of the New England states. In addition, Spanish is the relevant non-English language in the majority of states. The standard for Chinese, Tagalog or Navajo is met in a few counties affecting only five states: Alaska, Arizona, California, New Mexico and Utah.

- **Content of Notices:** The original regulation and subsequent technical guidance required all notices of adverse benefit determinations (EOBs) and final internal adverse benefit determinations (internal appeal determinations) to include specific information that identifies the claim, date of service, provider and claim amount (applicable for plan years beginning on or after July 1, 2011). In addition, the original regulation required such notices to include diagnosis and treatment codes and their corresponding meanings. The amended rule removes the requirement to include the codes and meanings and replaces it with the requirement to include a statement on the notices that the codes and their meanings are available upon request if the claimant believes the denial may have been due to a coding error.

- **Availability of State Consumer Assistance Programs:** The original regulation and subsequent technical guidance required all notices of adverse benefit determinations (EOBs), final internal adverse benefit determinations (internal appeal determinations) and external review determinations to include information on the availability of a state consumer assistance program. The technical guidance issued with the amended rule provides an updated list of states that have created such programs. Note: Even though self-funded plans are governed by ERISA and claimants must be directed to contact the Employee Benefit Security Administration, the notices must also include the contact information for any state consumer assistance program available to assist the claimant with the internal claims and appeals and external review process.

- **Model Notices:** The technical guidance issued with the amended rule provides new model notices for: 1) adverse benefit determinations (EOBs), 2) final internal adverse benefit determinations (internal appeal determinations), and 3) final external review determinations (IRO determinations). These model notices replace those issued on September 20, 2010. The adverse benefit determination and final adverse benefit determination model notices now include:

  a) Information on a claimant's rights to appeal the adverse determination including the right to external review and the right to request the diagnoses and treatment codes;
  b) Statements in the applicable non-English language of the availability of language assistance services; and
  c) Contact information for state consumer assistance programs.

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The final external review determination model notices now also include language based on the new requirements contained in the amended rule.

Since plans have an enforcement safe harbor period until plan years beginning on or after January 1, 2012 to implement the language translation rules and the statement regarding the availability of diagnoses and treatment codes on the notices (both of which are embedded in the new model notices), it is currently understood that plans have until the January 1, 2012 date to issue updated notices which include information on the claimant's appeals rights and the availability of state consumer assistance programs.

Implementation

Health Plans' Actions

Health Plans will take the following actions in order to implement and administer the requirement of the claims and appeals rules on behalf of your plan:

- *Amend Plan Document/Summary Plan Descriptions*: Over the next four to eight weeks **Health Plans** will issue updated amendments to the Claims and Appeals section of non-grandfathered plan documents to reflect the current rules. These amendments will supersede those that were included with the initial health care reform amendments, will include additional details regarding claimants' rights and will restore the original urgent care claim response deadline.

  Note: The DOL had earlier indicated that it would issue model language for SPDs regarding claims and appeals, but to date it has not. However, because claimants must be advised of their claims and appeals rights under the new rules, including the right to external review, we will amend your plans accordingly. Should the DOL issue model language, or should the Agencies further modify these rules, we will evaluate at that time whether further plan amendments will be necessary.

- *Revise Internal Administrative Claims and Appeals Processes*: We have modified our internal claims and appeals processes related to the requirements effective for plan years beginning on or after September 23, 2010. We will continue to modify our processes in accordance with the requirements of the new rules as they take effect (currently no later than for plan years beginning on or after January 1, 2012).

- *Issue Updated Claim and Appeal Notices*: We will update and modify our notices of adverse benefit determinations (EOBs) and final internal adverse benefit determinations (internal appeal determinations) to be consistent with the new requirements by January 1, 2012. Note: **Health Plans**' current notices are in compliance with the original regulation's requirement (applicable for plan years beginning on or after July 1, 2011) to include specific information that identifies the claim, date of service, provider and claim amount.

- *Contract with IROs and Coordinate External Review***:** We have entered into contracts with two IROs to perform external review services on behalf of your plans and are in discussions with a third IRO. We will coordinate the referral process to IROs on a random rotating basis as required, guiding you through the external review process and providing you with all required documentation, including the IRO determination.

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Measuring Plan Changes to Determine Grandfathered Status

By September 23, 2011, the end of the first year for implementation of the group health plan mandate requirements of federal health care reform, many, but not all plans will have lost grandfathered status. For those plans that have retained grandfathered status, here is a quick refresher about how to measure plan changes going forward.

The list below highlights the most common reasons a plan can lose grandfathered status:

- Deductibles or out-of-pocket maximums in effect on March 23, 2010 are increased by more than the *rate of medical inflation** plus 15 percentage points
- Copayments in effect on March 23, 2010 are increased by more than the greater of $5.00 increased by the *rate of medical inflation**, or the percentage *rate of medical inflation** plus 15 percentage points

  *The *rate of medical inflation* is measured as the difference between the medical care component of the Consumer Price Index-Urban (CPI-U) as of March 2010 (387.142) and the highest medical care component CPI-U amount for any of the 12 months before the plan change. If the plan change is made less than 12 months after March 2010, the formula uses the highest monthly CPI-U medical care component amount since March 2010. The CPI-U is updated on a monthly basis, generally mid-month, to add the prior month's index amounts.

- Coinsurance percentages in effect for members on March 23, 2010 are increased by any amount
- The employer contribution rate in effect on March 23, 2010 is decreased by more than 5 percentage points (applicable to each tier and coverage classification; e.g., if the employer maintains the employee rate of contribution but increases the family rate by more than 5%, plan loses grandfathered status)

Important:
When you measure changes to your plan for the purpose of determining grandfathered status, remember to measure the *cumulative* change in the plan **since March 23, 2010.**

For example, if office visit copayments under the plan were increased by $5.00 on January 1, 2011, and then increase by an additional $5.00 on January 1, 2012, the cumulative change would be $10.00.

Tip:
Use the Plan Grandfathering Calculator available through the Client page* of the **Health Plans** web site at https://www.healthplansinc.com to help determine whether future plan changes under consideration are likely to cause a loss of grandfathered status.

Health Plans updates the calculator's database monthly with the latest medical care component of the CPI-U Index.

***** Brokers can also access the calculator through the Broker page of our website.

Please also refer to our August 20, 2010 *Compliance Bulletin* for comprehensive information about the grandfathering rules and all the reasons a plan could lose grandfathered status.

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Proposed Regulation on Summary of Benefits and Coverage (SBC)

On August 22, 2011, the Agencies issued a proposed regulation under the Affordable Care Act that requires plans to provide applicants and enrollees with a uniform Summary of Benefits and Coverage (SBC). The SBCs are intended to enable consumers to more easily understand their health coverage and make apples-to-apples comparisons of available options. The regulations propose standards governing who provides and who receives an SBC, how and when an SBC is provided, and the content of the SBC.

The Agencies are soliciting general comments, as well as input about specific issues regarding the proposed regulation from interested parties until October 22, 2012. Sometime after the comment period closes, the Agencies will issue a final regulation. Because further changes to the proposed regulation are expected in the final regulation, **Health Plans** will wait until the final regulation is issued before advising you about the specific requirements for SBCs.

The final regulation should (we hope) include additional guidance about the following:

- **Implementation deadline:** The proposed regulation still includes March 23, 2012 as the implementation deadline for plans to issue SBCs. However, the original deadline under the Affordable Care Act was a year from the deadline for the DOL to issue model notices (March 23, 2011). Because of the missed deadline by the DOL, the extensive content requirements (including illustrations of the out-of-pocket costs for certain services based on specific plan design) and the additional burden for plans to create eight-page SBCs*, the DOL specifically asked for input on the implementation timeline. Until the final regulation is issued, we cannot be certain about when plans must start issuing SBCs.

- **Content and layout:** The Agencies issued model SBCs with the proposed regulation with over 30 pages of instructions, incorporating strict rules for content and layout. (One commentator made an analogy to the nutritional information labels on packaged food – all have to have the same content and use the same terms so that consumers can compare.) The proposed regulation does not address what changes in length or format will be permitted to show benefits for plans with more than two tiers of coverage or whether the format must include the specific colors and fonts shown in model notices.

- **Application to group health plans:** There is some question about how the requirements related to SBCs apply to employee group health plans that are also regulated by other ERISA notice requirements. Plans would be required to issue SBCs in addition to SPDs. The introduction to the proposed regulation also specifically solicits comments regarding how the distribution of the SBC might be coordinated with other ERISA disclosures.

Health Plans' Actions: Until the final regulation is issued, we will not know when plans will need to start issuing SBCs, or what the specific parameters will be. However, please rest assured that **Health Plans** will produce the SBCs for your plan(s) based upon the requirements included in the final regulation. Soon after we have received definitive guidance, we will issue a *Compliance Bulletin* that will focus on SBCs.

*The Affordable Care Act called for a four-page summary. The Agencies have interpreted this to mean four double-sided pages, or eight pages of content. The model notices show a six-page SBC with an accompanying two-page glossary.

If you have questions about the material in this *Bulletin* or other issues related to health care reform, please contact your **Health Plans** Account Manager.