HOLLAND&HART LLP
BENEFITS LAW GROUP

News Alert

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Health Care Reform Guidance on Preventive Services and Claims Procedures Impacts Next Year's Plan Design and Grandfathered Plan Decisions

The specifics of many of the mandates under the Patient Protection and Affordable Care Act (as amended by the Health Care and Education Reconciliation Act of 2010) (together, the "Act") were left to be established by the Department of the Treasury, the Department of Labor (DOL), and the Department of Health and Human Services. These agencies have now jointly released interim final regulations that plan sponsors must consider when making design decisions and changes in their group health plans for the upcoming plan year. The most recent guidance covers several requirements of the Act that are effective for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans): coverage of preventive services, and new internal claims review and external appeals procedures for group health plans.

These requirements do not apply to group health plans that are "grandfathered plans." In short, a "grandfathered plan" is a plan that was in existence on March 23, 2010, and that has not been modified except as allowed under regulations. For more information on grandfathered plan status, see our previous alert, Interim Final Regulations Address Grandfathered Plans Under the Health Care Act. This new guidance--and the scope of the exemption for grandfathered plans--may affect the decision of plan sponsors as to whether to make the effort to maintain a plan's grandfathered status.

Preventive Services

The Act requires group health plans to provide certain preventive services, and there can be no participant cost-sharing on those preventive services. This means that no co-pay, coinsurance, or deductible can be charged for the service. The current required preventive services are:

- Screening tests or evidence-based items or services currently recommended by the United States Preventive Services Task Force such as breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling.

- Immunizations for routine use in children, adolescents, and adults currently recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents including regular pediatrician visits, vision and hearing screening, developmental assessments, and screening and counseling to address obesity.

- Preventive care and screenings for women provided for in the comprehensive guidelines currently being developed by the HRSA. These guidelines are expected to be issued by August 1, 2011.

The preamble to the regulations includes the current recommendations and guidelines, and the following website will show any changes:

http://www.HealthCare.gov/center/regulations/prevention.html

Most of the required preventive services must be provided at no cost for plan years beginning on or after September 23, 2010. However, recommendations that went into effect on or after September 23, 2009, would not be required preventive services until the next plan year. Plans must keep up-to-date with the changes in recommended preventive services, but will not be required to implement the change until at least one year after the change in the recommendation.

The guidance outlines several circumstances in which cost-sharing is permitted. If a service that was previously recommended as a preventive service is no longer recommended as such, a plan is no longer required under the Act to provide the service (subject to other Act requirements for advance notice to participants), and may impose cost-sharing on the service if it does. Additionally, a plan is not required to provide preventive services if they are delivered by an out-of-network provider. If they are provided on an out-of-network basis, cost-sharing requirements may be imposed. Also, if the preventive service guidelines do not specify the frequency, method, treatment or setting for the service, the plan can use reasonable medical management techniques to determine any coverage limitations. If a plan covers preventive services beyond those that are required, the plan can impose cost-sharing requirements on those additional services.

The regulations also address when cost-sharing can be imposed where the covered preventive service is provided in conjunction with an office visit. The answer depends on how the preventive service is billed. If the service is billed separately from the office visit (or tracked as an individual encounter data separately), then cost-sharing can be imposed on the office visit itself. If not, and the primary purpose of the office visit was to obtain the preventive service, then the plan cannot impose cost-sharing. However, if the primary purpose of the office visit was not to obtain the preventive service, then there can be cost-sharing. Multiple examples are provided in the guidance.

Internal Claims Review and External Review of Appeals

The Act imposes new rules for internal claims review and adds an external review process for appeals.

Internal Claims Review

Group health plans must have an internal claims review process that complies with the DOL's claims procedures requirements, as updated from time to time. Plans that are subject to ERISA must already comply with these requirements, but the Act expands the requirements to non-ERISA plans (and to issuers) and imposes additional rules. In particular:

- The definition of "adverse benefit determination" has been expanded and includes a rescission of coverage (whether or not there is an adverse effect on any particular benefit at that time) in addition to a denial, reduction, or termination of or a failure to provide or make a payment (in whole or in part) for a benefit.

- A plan must make a determination of an urgent care claim as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim, unless the claimant fails to provide sufficient information (compared to a 72 hour requirement under current DOL rules).

- The regulations provide more criteria for determining whether a claimant receives a full and fair review and specify additional information that must be provided to claimants.

- There are new rules for avoiding conflicts of interest. All claims and appeals must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Decisions as to whether to hire a claims adjudicator or medical expert cannot be based on the likelihood that the individual will support a denial of benefits.

- Additional notice requirements apply, as further described below (applicable to both internal and external review).

Failure to strictly adhere to all of the internal review requirements results in a claimant being deemed to have exhausted the internal claims and appeals process and allows the claimant to pursue external review (or possibly civil action), even if the plan has substantially complied with the requirements or the error was *de minimis*. Therefore, plan sponsors and third-party administrators must take utmost care to ensure that the new requirements are followed.

The preamble to the regulations notes that the DOL is considering further updates to its ERISA claims procedure regulations. Any updates would presumably apply to grandfathered plans as well as non-grandfathered plans, so the benefit of being a grandfathered plan in this context might be eliminated in the future.

External Review of Appeals

Many insured group health plans are already subject to an existing State external review process. Those plans must continue to follow the applicable State process and are not subject to the Federal external review process, provided that the State process complies with the minimum consumer protections of the National Association of Insurance Commissioners (NAIC) Uniform Model Act. There is a transition period for States to update their processes accordingly: plans that follow existing State review processes are deemed to comply until plan years beginning on or after July 1, 2011, at which time the required consumer protections must be in place.

The regulations describe what parts of the NAIC Uniform Model Act are considered minimum consumer protections that the State appeals process must include. One of the requirements is that the issuer (or the plan) would have to pay for the cost of an independent review organization (IRO) to conduct the external review (or the process could provide that the State would pay), although the claimant may be charged a nominal fee for requesting the external review. The State must maintain a list of approved, independent IROs, and IROs must be assigned to claims randomly or on an otherwise impartial basis. The external review decision is binding on the plan and the claimant, except to the extent that other remedies are available under State or Federal law.

Plans such as self-insured plans that are not subject to a State external review process will now be subject to a Federal external review process for plans years beginning on or after September 23, 2010. The Federal external review process applies to the same types of plan decisions as do the internal claims review rules, except that eligibility determinations will not be

reviewed. The Federal external review process is intended to be similar to the requirements for a State external review

process. More guidance on the Federal external review process is expected to be issued soon, including specific guidance on how self-insured plans may be brought into compliance.

Notices of Review and Appeals Processes

The Act also requires plans to provide notice to participants of the applicable review processes and the availability of assistance. The notice must comply with the content requirements of the DOL claims procedure regulations on notices of adverse benefit determinations and also must give additional disclosures. The additional disclosures include: (1) information sufficient to identify the claim: the date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the meaning of those codes; (2) the standard that was used in denying the claim (e.g., a description of the medical necessity standard, if medical necessity was the reason for denial); (3) if the decision was a final internal adverse benefit determination, a discussion of the decision; (4) a description of available internal appeals and external review processes, including information on how to initiate an appeal; and (5) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Act to assist enrollees with the processes. The DOL intends to issue model notices but plan sponsors also should be working with claims administrators or insurers to ensure enrollment materials and plan summaries are consistent with this requirement.

Pursuant to the Act, the notice must be provided "in a culturally and linguistically appropriate manner." This means that, similar to the current requirement for summary plan descriptions, the plan may have to provide the notice in a non-English language upon request, and the notice may need to include a statement on the availability of the non-English notice. This requirement applies if at least 25% of plan participants (or, for plans with 100 or more participants, the lesser of 10% of plan participants or 500) are literate only in that non-English language. Once a request for a non-English notice is made, all future notices to the claimant must be provided in that non-English language. Consumer assistance processes, such as hotlines, may also be required to be provided in the non-English language.

To read more about other health care reform guidance issued by the regulatory agencies, visit the Holland & Hart website and read "Proposed Regulations Address Preexisting Condition Exclusions, Lifetime and Dollar Limits, Rescissions & Patient Protections Under the Health Care Act".

Due to the quick effective date of these regulations, plan sponsors need to review the affect of the rules on their plans as soon as possible. For assistance, or if you have questions about any other employee benefit matters, please contact a member of our Benefits Law Group.

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