



**TBG *Ask the Expert Series***

Health Care Reform:

Open Enrollment Compliance Checklist



## **Table of Contents**

<b><u>Open Enrollment Compliance Checklist</u></b>	<b><u>Page 3</u></b>
<b><u>Regulations Issued on Grandfathered Plans</u></b>	<b><u>Page 6</u></b>
<b><u>Grandfather Notice</u></b>	<b><u>Page 10</u></b>
<b><u>Interim Final Rules: Dependent Coverage Under Age 26</u></b>	<b><u>Page 11</u></b>
<b><u>Model Language: Dependent Coverage Under Age 26</u></b>	<b><u>Page 15</u></b>
<b><u>IRS Issues Guidance on Tax-Free Coverage for Under Age 27</u></b>	<b><u>Page 16</u></b>
<b><u>Interim Final Rules on Patient's Bill of Rights</u></b>	<b><u>Page 17</u></b>
<b><u>Patient Protection Model Disclosure</u></b>	<b><u>Page 21</u></b>
<b><u>Interim Final Rules on New Appeals Process</u></b>	<b><u>Page 22</u></b>
<b><u>Appeals Process</u></b>	<b><u>Page 26</u></b>
<b><u>Preventive Care Coverage Guidelines Issued</u></b>	<b><u>Page 28</u></b>
<b><u>Changes to Health Accounts</u></b>	<b><u>Page 30</u></b>
<b><u>Model Language: Notice Lifetime Limit No Longer Applies</u></b>	<b><u>Page 32</u></b>



## **Open Enrollment Compliance Checklist**

### **Introduction**

Health care reform, in the form of the Patient Protection and Affordable Care Act, brings many changes for employers and their health plans. As sponsors of group health plans prepare to comply with health care reform's many requirements, they need to be aware of how health care reform will affect their plans for the coming plan year. Many changes are effective on the first day of the **first plan year beginning on or after September 23, 2010, or January 1, 2011** for calendar year plans.

This **TBG** Legislative Brief provides a compliance checklist for employers to review in advance of the 2011 plan year and open enrollment season. Please contact your **TBG** representative for assistance.

### **Compliance Checklist**

#### ***Grandfathered Plan Status***

- Determine if you have a grandfathered plan.
  - A grandfathered plan is one that was in existence when health care reform was enacted on March 23, 2010.
  - Grandfathered plans are exempt from some of the health care reform requirements.
  - If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact your **TBG** representative if you have questions about changes you have made, or are considering making, to your plan.

#### ***Plan Amendments – All Plans***

Plan sponsors should take the following actions prior to the **first day of the plan year beginning on or after September 23, 2010** (unless a different effective date is noted):

- Amend plans to **cover dependents up to age 26**.
  - If your plan is grandfathered, it is not required to cover adult children who are eligible for coverage sponsored by their employer for plan years beginning on or before January 1, 2014.
- Amend plans to **eliminate lifetime limits** on essential benefits and to provide that individuals who previously reached the lifetime limit under the plan and who are otherwise eligible for coverage may re-enroll in the plan and will not be affected by the lifetime limit.
- Amend plans to either **eliminate or restrict annual limits** on essential benefits.
  - Annual limits are being phased out over the next three years.
  - For plan years beginning on or after September 23, 2010, a plan may impose a minimum annual limit of \$750,000.
  - For plan years beginning on or after September 23, 2011, a plan may impose a minimum annual limit of \$1.25 million.
  - For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a plan may impose a minimum annual limit of \$2 million.
- Amend plans to eliminate **pre-existing condition exclusions** for children under age 19.
  - Pre-existing condition exclusions will be eliminated altogether for plan years beginning on or after January 1, 2014.



- Amend plans that include tax-advantaged medical accounts, such as **FSA**s, **HSAs**, **HRAs** or **Archer MSAs**, to reflect new requirements.
  - Plans that permit reimbursement of **over-the-counter medicine or drugs** must be amended prior to **January 1, 2011** to provide that these expenses are reimbursable only with a doctor's prescription (except for insulin) if they are incurred after December 31, 2010.
  - Plans that cover expenses of dependents must be amended to be consistent with any dependent eligibility changes related to the **age 26 rule**.
- Amend plans to incorporate new rules regarding **rescissions**.
  - A rescission is a termination of coverage that has a retroactive effect. However, a retroactive cancellation is not a rescission to the extent it is caused by a failure to pay premiums.
  - Rescissions are only permitted in cases of fraud or intentional misrepresentation of a material fact.

#### ***Plan Amendments – Non-Grandfathered Plans Only***

Plan sponsors of non-grandfathered plans should also take the following actions prior to the **first day of the plan year beginning on or after September 23, 2010**:

- Amend plans to cover recommended **preventive services** with no cost-sharing requirements.
- Establish an effective **claims appeal process** by amending current claims procedures to incorporate new definitions and requirements.
  - Revise definition of adverse benefit determination.
  - Update deadline for notice regarding urgent care claims.
  - Adopt procedures to provide full and fair review and avoid conflicts of interest.
  - Provide culturally and linguistically appropriate notices regarding the process and options for assistance.
  - Ensure plan is following appropriate external review process.
- Amend fully-insured plans to eliminate **impermissible discrimination** in favor of highly compensated employees.
  - Plans may not longer discriminate with respect to eligibility or benefits.
- Amend plans to include **patient protections**.
  - If the plan requires participants to choose a primary care provider, allow participant to choose any available participating primary care provider or pediatrician.
  - Permit participants to obtain OB/GYN care without a pre-authorization or referral.
  - Eliminate pre-authorization requirement for emergency services.
  - Eliminate increase coinsurance or copayment requirements for out-of-network emergency services.



### **Special Enrollment Opportunities**

- Provide a 30-day special enrollment opportunity (and notice) to adult children eligible for coverage under the **age 26 rule**.
  - The enrollment opportunity (and notice) must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.
  - The coverage must begin no later than the first day of the first plan year beginning on or after September 23, 2010.
- Provide a 30-day special enrollment opportunity (and notice) to individuals who have **reached the lifetime limit** under the plan but are otherwise eligible for coverage.
  - The enrollment opportunity (and notice) must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.
  - The coverage must begin no later than the first day of the first plan year beginning on or after September 23, 2010.

### **Participant Notices**

If you have a grandfathered plan, you must include **information about the plan's grandfathered status** in plan materials describing the coverage under the plan, such as summary plan descriptions (SPDs) and open enrollment materials. This information must inform participants that the plan is not subject to some of the consumer protections of the health care reform law. Model language is available regarding this requirement.

There are a number of other health care reform provisions that require notices to be provided to plan participants. **Model notices** are available for some of these notices at [www.dol.gov/ebsa/healthreform/](http://www.dol.gov/ebsa/healthreform/).

Employers should make sure they are prepared to provide the following notices prior to the **first plan year beginning on or after September 23, 2010** (unless another deadline is noted). To be thorough, plans should include these notices in their SPDs, as applicable.

- Notice that eligibility for dependent coverage has been extended for children up to **age 26** (including any restrictions for grandfathered plans) and that a special enrollment period is available for eligible dependents. A model notice is available.
- Notice to participants affected by a **lifetime limit** (including former participants that are otherwise eligible for coverage) that the lifetime limit no longer applies to them and they are eligible for a special enrollment opportunity if they are no longer enrolled in the plan. A model notice is available.
- Notice to participants in non-grandfathered plans regarding the **patient protections** that are available. A model notice is available.
- Prior to **January 1, 2011**, notice should be provided to employees that **over-the-counter medication and drugs** (except insulin) may only be reimbursed through medical account plans with a prescription.

Going forward, plans will be required to provide certain notices to plan participants, including the following:

- Written notice of any **rescission** must be provided at least 30 days in advance.
- Non-grandfathered plans must provide a culturally and linguistically appropriate notice to participants regarding the **new appeals process** and their options for assistance.



## **Regulations Issued on Grandfathered Plans**

### **EXECUTIVE SUMMARY**

The health care reform law passed earlier this year brings many changes to employers and health plans. The extent of the impact will depend, in part, on whether you maintained a health care plan on March 23, 2010, the date the primary legislation was enacted. If your company sponsored a plan on that date, it is considered a "grandfathered" plan. Grandfathered plans are exempt from certain health care reform requirements, such as no cost-sharing for preventive care and other patient protections.

On June 14, 2010, the Departments of Health and Human Services (HHS), Labor and Treasury issued regulations regarding grandfathered plans. Importantly, it clarifies what types of changes can be made to existing plans that will allow them to retain their "grandfathered" status.

This **TBG** Legislative Brief summarizes the new regulations as follows.

### **SUMMARY OF THE REGULATIONS**

The regulations essentially state that plans will lose their grandfathered status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers. Losing grandfathered status means that a plan would have to comply with additional health care reform requirements, such as first-dollar coverage of recommended prevention services and patient protections such as guaranteed access to OB-GYNs and pediatricians.

#### **Permitted Changes**

Grandfathered health plans will be able to make routine changes to their policies and maintain their status. These routine changes include cost adjustments to keep pace with medical inflation, adding new benefits, making modest adjustments to existing benefits, voluntarily adopting new consumer protections under the new law, or making changes to comply with state or other federal laws. Premium changes are not taken into account when determining whether or not a plan is grandfathered.

#### **Prohibited Changes**

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. Specifically, making the following changes would cause a plan to lose its grandfathered status:

- Significantly Cutting or Reducing Benefits. For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- Raising Co-Insurance Charges. Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.
- Significantly Raising Co-Payment Charges. Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next two years, it will lose its grandfathered status.
- Significantly Raising Deductibles. Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000 or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these

deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-5 percent so this formula would allow deductibles to go up, for example, by 19-20 percent between 2010 and 2011, or by 23-25 percent between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.

- Significantly Reducing Employer Contributions. Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).
- Adding or Tightening an Annual Limit on What the Insurer Pays. Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
- Cannot Change Insurance Companies. If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.

### **Transition Relief**

The regulations contain some transition relief for plans that may have made changes before the regulations were issued and thus before plan sponsors knew what changes were permissible. The transition relief that is available depends on when the changes were made.

If a group health plan (or health insurance issuer) made legally binding changes to the terms of the plan or coverage on or after March 23, 2010, those changes will be considered part of the plan or coverage on March 23, 2010, even if the changes were not yet effective on that date. A change is considered legally binding if it was made pursuant to a contract, a filing with a state insurance department or a written amendment to the plan that was entered into, made or adopted on or before March 23, 2010.

The regulations also provide transition relief for changes made to plans after the health care reform law was enacted on March 23, 2010, and before the regulations were available on June 14, 2010. If a group health plans or health insurance issuer made changes after March 23, 2010 that were adopted prior to June 14, 2010 and would cause the plan to lose grandfathered status, the plan has a grace period to revoke or modify the changes.

Under this rule, grandfathered status is preserved if the changes are revoked and the plan is modified, effective as of the first day of the first plan year beginning on or after September 23, 2010, to bring the terms of the plans within the limits for retaining grandfathered status.

### **Additional Requirements for Grandfathered Plans**

The regulations also contain additional requirements to keep health plans from using the grandfather rule to avoid providing important consumer protections.

To promote transparency, the regulations require a plan to disclose to consumers, every time it distributes materials, whether the plan believes that it is a grandfathered plan and therefore is not subject to some of the additional consumer protections of the health care reform law. This allows



consumers to understand the benefits of staying in a grandfathered plan or switching to a new plan. The plan must also provide contact information for enrollees to have their questions and complaints addressed.

The regulations also provide that a plan's grandfathered status may be revoked if it forces consumers to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing as a means of avoiding new consumer protections. Grandfathered status may also be revoked if a plan is bought by or merges with another plan simply to avoid complying with the law.

### **PROJECTED IMPACT ON CONSUMERS AND PLANS**

The Departments have provided information on the expected impact the grandfathered plan rules will have on health coverage. For additional information, access the fact sheet at: [www.healthreform.gov/newsroom/keeping\\_the\\_health\\_plan\\_you\\_have.html](http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html).

#### **Large Employer Plans**

It is expected that large employers (100 or more workers) - who make up the vast majority of those with private health insurance today - will not see major changes to their coverage as a result of this regulation. The regulations affirm that most of these plans will remain grandfathered - more than three-quarters of firms in 2011 - based on the way they changed cost sharing from 2008-2009.

Most of these plans already offer the patient protections applied to grandfathered plans such as no pre-existing condition exclusions for children and no rescissions of coverage when a person gets sick. In addition, they are likely to already give their workers and families protections like a choice of OB-GYN and pediatrician, and access to emergency rooms in other states without prior authorization. Based on past patterns of behavior, it is expected that large employers will continue to make adjustments to the health plans they offer from year to year so that, by the time the health insurance Exchanges are established in 2014, fewer - but still most - large employer plans will have grandfather status. However, the assumed market changes depend on the choices large employers make in the future.

#### **Small Business Plans**

The roughly 43 million people insured through small businesses will likely transition from their current plan to one with the new protections over the next few years. Small plans tend to make substantial changes to cost sharing, employer contributions, and health insurance issuers more frequently than large plans. As such, it is estimated that 70 percent of plans will be grandfathered in the first year, but depending on the choices these employers make, this could drop to about one-third over several years.

#### **Individual Health Market**

The 17 million people who are covered in the individual health insurance market, where switching of plans and substantial changes in coverage are common, are expected to receive the health care reform protections sooner rather than later. Roughly 40 percent to two-thirds of people in individual market policies change plans within a year. Given this "churn," the transition for the 17 million people in this market may be swift, irrespective of the grandfather plan definition.

#### **Special Types of Health Plans**

Fully-insured health plans subject to collective bargaining agreements will be able to maintain their grandfathered status until their agreement terminates. After that point, they are subject to the same rules as other health plans; in other words, they will lose their grandfathered status if they



make any of the substantial changes described above. Retiree-only and “excepted health plans” such as dental plans, long-term care insurance, or Medigap, are exempt from the health care reform insurance reforms.

This **TBG** Legislative Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

Content © 2010 Zywave, Inc. Images © 2000 Getty Images, Inc. All rights reserved.

EAS 7/10



### **Grandfather Notice**

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

The following model language can be used to satisfy this disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]



## **Interim Final Rules on Dependent Coverage of Children Up to Age 26**

### **EXECUTIVE SUMMARY**

The Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (the Reconciliation Act), provides that health plans and issuers that offer dependent coverage to children on their parents' plans must make the coverage available until the adult child reaches the age of 26. The Departments of Health and Human Services (HHS), Labor and Treasury have issued interim final rules relating to this requirement.

- The interim final rules clarify that qualified dependents must be offered the same coverage that is available to similarly situated individuals and cannot be required to pay more. They also provide a special enrollment opportunity for qualified dependents not currently covered.
- Note that the requirement to extend coverage applies only to plans that offer dependent coverage in the first place. Most insurers and employer-sponsored plans offer dependent coverage, but there is no legal requirement to do so.
- The interim final rules complement guidance issued by the Treasury Department on April 27, 2010, on the tax benefits for dependent coverage. Under a new tax provision in the Reconciliation Act, the value of employer-provided health coverage for an employee's child is excluded from income through the end of the taxable year in which the child turns 26, effective March 30, 2010.

This **TBG** Legislative Brief summarizes key points of the interim final rules. Please read below for further information. We will continue to monitor legislative and regulatory developments related to these rules and health care reform.

### **EXPLANATION OF THE INTERIM FINAL RULES**

#### **General Rule**

The interim final rules incorporate PPACA's requirement that health plans and issuers that make available dependent coverage of children, must make the coverage available for children until they reach 26 years of age.

*Example:* For the plan year beginning January 1, 2011, a group health plan provides health coverage for employees, employees' spouses and employees' children until the child turns 26. On the birthday of a child of an employee, July 17, 2011, the child turns 26. The last day the plan covers the child is July 16, 2011. This plan satisfies the requirements of the interim final rules.

#### **Restrictions on Plan Definition of Dependent**

The interim final rules also address a plan's definition of the term "dependent." They state that a plan or issuer may not define dependent for purposes of eligibility "other than in terms of a relationship between a child and the participant." This means that coverage may not be denied for a child who is under age 26 based on the following factors (or any combination of them):

- The presence or absence of the child's financial dependency (upon the participant or any other person);
- Residency with the participant or with any other person;
- Student status;



- Employment; or
- Eligibility for other coverage (unless the plan is a grandfathered plan and the child is eligible for other employer-sponsored coverage before January 1, 2014).

The rules specifically state that plans and issuers are not required to make coverage available for the child of a dependent receiving coverage.

### **Uniformity in Plan Terms**

PPACA did not specifically address benefit packages or the cost of benefits available to dependents who are eligible for coverage under the new law. However, the interim final rules specifically state that the terms of the coverage cannot vary based on age (except for children who are age 26 or older). This means that qualified dependents must be offered all of the benefit packages available to similarly situated individuals who did not lose coverage because of cessation of dependent status. Also, these dependents cannot be required to pay more for coverage than those similarly situated individuals.

The interim final rules provide examples illustrating the uniformity requirement.

*Example:* A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not reached age 26. The plan imposes an additional premium surcharge for children who are older than age 18. This plan violates the interim final rules because the plan varies the terms for dependent coverage of children based on age.

*Example:* A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not reached age 26. In this example, the plan does not violate the interim final rules. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

*Example:* A group health plan offers two benefit packages -- an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not reached age 26. The plan limits children who are older than age 18 to the HMO option. This plan violates the uniformity requirement because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

### **Special Enrollment Opportunities for Dependents**

Before the coverage requirement becomes effective, a child who was covered under a group health plan or health insurance coverage as a dependent may lose or have lost eligibility under the plan due to age prior to age 26. Also, a child may not have been eligible for coverage if his or her parent first became covered under the plan when the child was under age 26 but older than the plan's eligible age.

The interim final rules attempt to remedy this situation by providing all eligible dependents with a special enrollment opportunity. For a child to be eligible for special enrollment, his or her coverage must have ended (or not been offered) before the age of 26 and he or she must be eligible for extended coverage under PPACA.

Plans must provide these dependents with an opportunity to enroll which continues for at least 30 days, along with written notice of the opportunity to enroll. The opportunity (including the written



notice) must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. This rule applies regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur.

The written notice of the special enrollment opportunity must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before age 26, are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child and may be included with other enrollment materials.

The coverage for dependents who enroll through a special enrollment opportunity must take effect no later than the first day of the first plan year beginning on or after September 23, 2010. Also, these dependents must be treated as special enrollees (as under HIPAA).

### **Special Enrollment Examples**

The interim final rules include a number of examples explaining the special enrollment rights.

*Example:* Employer Y maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For the 2010 plan year, the plan allows children of employees to be covered under the plan until age 19, or until age 23 for children who are full-time students. Individual B, an employee of Y, and Individual C, B's child and a full-time student, were enrolled in Y's group health plan at the beginning of the 2010 plan year. On June 10, 2010, C turns 23 years old and loses dependent coverage under Y's plan. On or before January 1, 2011, Y's group health plan gives B written notice that individuals who lost coverage by reason of ceasing to be a dependent before reaching age 26 are eligible to enroll in the plan, and that individuals may request enrollment for such children through February 14, 2011 with enrollment effective retroactively to January 1, 2011.

In this example, the plan has complied with the special enrollment requirements by providing an enrollment opportunity to C that lasts at least 30 days.

*Example:* Employer Z maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan allows children of employees to be covered under the plan until age 22. Individual D, an employee of Z, and Individual E, D's child, are enrolled in family coverage under Z's group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, E turns 22 years old and ceases to be eligible as a dependent under Z's plan and loses coverage. D drops coverage but remains an employee of Z.

In this example, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

*Example:* Same facts as the preceding example, except that D did not drop coverage. Instead, D switched to a lower-cost benefit package option.

In this example, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible.

*Example:* Same facts as the preceding examples, except that E elected COBRA continuation coverage.

In this example, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll other than as a COBRA qualified beneficiary (and must provide, by that date, written notice of



the opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

*Example:* Employer X maintains a group health plan with a calendar year plan year. Prior to 2011, the plan allows children of employees to be covered under the plan until the child reaches age 22. During the 2009 plan year, an individual with a 22-year-old child joins the plan; the child is denied coverage because the child is 22.

In this example, notwithstanding that the child was not previously covered under the plan, the plan must provide the child, not later than January 1, 2011, an opportunity to enroll (including written notice to the employee of an opportunity to enroll the child) that continues for at least 30 days, with enrollment effective not later than January 1, 2011.

### **Applicability Dates**

The interim final rules apply to group health plans and insurance issuers for plan years beginning on or after September 23, 2010. Similarly, they apply to individual health insurance issuers for policy years beginning on or after September 23, 2010.

However, for plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan under PPACA, and makes dependent coverage of children available, may exclude an adult child under age 26 from coverage if the adult child is eligible to enroll in an employer-sponsored health plan, other than a group health plan of a parent.

These applicability dates are consistent with the effective dates of PPACA's provisions.

### **Early Implementation**

Although the law provides for a delayed effective date, many insurance carriers have agreed to implement the coverage requirements early. This will avoid gaps in coverage for new college graduates and other young adults. It will also save administrative costs of dis-enrolling and re-enrolling them.

### **More Information**

Click [here](#) for a copy of the interim final rules, as published in the Federal Register on May 13, 2010.

See this [HHS page](#) for a list of insurance companies that have agreed to implement the dependent coverage requirement before the September 23, 2010 deadline.

*This TBG Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.*

Content © 2010 Zywave, Inc. Images © 2000 Getty Images, Inc. All rights reserved.

ES 5/10



**Model Language for Notice of Opportunity to Enroll  
in Connection with Extension of Dependent Coverage to Age 26**

The interim final regulations extending dependent coverage to age 26 provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The regulations require a plan or issuer to give such a child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year beginning on or after September 23, 2010. The notice may be included with other enrollment materials that a plan distributes, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].



## **IRS Issues Guidance on Tax-Free Coverage for Children Under Age 27**

### **IRS Issues Notice 2010-38**

As a result of changes made by the recently enacted Affordable Care Act, health coverage provided for an employee's children under 27 years of age is now generally tax-free to the employee, **effective March 30, 2010.**

The Internal Revenue Service announced on April 27, 2010 that these changes immediately allow employers with cafeteria plans – plans that allow employees to choose from a menu of tax-free benefit options and cash or taxable benefits – to permit employees to begin making pretax contributions to pay for this expanded benefit.

IRS [Notice 2010-38](#) explains these changes and provides further guidance to employers, employees, health insurers and other interested taxpayers.

"These changes give employers a unique opportunity to offer a worthwhile benefit to their employees," IRS Commissioner Doug Shulman said. "We want to make it as easy as possible for employers to quickly implement this change and extend health coverage on a tax-favored basis to older children of their employees."

### **Who is Eligible for the Tax Benefit?**

This expanded health care tax benefit applies to various workplace and retiree health plans. It also applies to self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return.

Employees who have children who will not have reached age 27 by the end of the year are eligible for the new tax benefit from March 30, 2010, forward, if the children are already covered under the employer's plan or are added to the employer's plan at any time. For this purpose, a child includes a son, daughter, stepchild, adopted child or eligible foster child. This new age 27 standard replaces the lower age limits that applied under prior tax law, as well as the requirement that a child generally qualify as a dependent for tax purposes.

### **Pretax Contributions Permitted Immediately, Plan Amendment Required Later**

The notice says that employers with cafeteria plans may permit employees to immediately make pretax salary reduction contributions to provide coverage for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals. Plan sponsors then have until the end of 2010 to amend their cafeteria plan language to incorporate this change.

In addition to changing the tax rules as described above, the Affordable Care Act also requires plans that provide dependent coverage of children to continue to make the coverage available for an adult child **until the child turns age 26**. The extended coverage must be provided no later than **plan years beginning on or after Sept. 23, 2010**. The favorable tax treatment described in the notice applies to that extended coverage.

*Source: Internal Revenue Service*

This **TBG** Legislative Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

Content copyright © 2009-2010 Zywave, Inc. Images copyright © 2000 Getty Images, Inc. All rights reserved.  
EAS 4/10



## **Interim Final Rules on a Patient's Bill of Rights**

### **EXECUTIVE SUMMARY**

The Departments of Treasury, Labor (DOL) and Health and Human Services (HHS) have issued interim final rules related to the provisions of the Patient Protection and Affordable Care Act (PPACA) regarding pre-existing condition exclusions, lifetime and annual limits, rescissions and other patient protections. Most of these provisions are effective for plan years beginning on or after **September 23, 2010**.

Plan sponsors should become familiar with these requirements in order to determine whether the new rules apply to their plans and whether their plans must be amended accordingly.

This **TBG** Legislative Brief describes the provisions of PPACA regarding these rules, as well as the clarifications made by the interim final rule. Please read below for more information.

### **EXPLANATION OF THE INTERIM FINAL RULE**

#### **Pre-existing Condition Exclusions**

PPACA prohibits any pre-existing condition exclusions from being imposed by group health plans or group health insurance coverage, including grandfathered group health plans. PPACA also extends this prohibition to individual health insurance coverage, although it does not apply to grandfathered individual policies.

This prohibition generally is effective with respect to plan years beginning on or after **January 1, 2014**. However, for enrollees who are under 19 years of age, this prohibition takes effect for plan years beginning on or after **September 23, 2010**.

A pre-existing condition exclusion is a limitation or exclusion of benefits related to a condition, based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Based on this definition, PPACA prohibits exclusions of coverage of specific benefits and a complete exclusion from a plan based on a pre-existing condition.

Until these new rules take effect, the rules regarding pre-existing condition exclusion rules in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will continue to apply. The rules do not change the HIPAA rule that an exclusion of benefits for a certain condition under a plan is not a pre-existing condition exclusion if the exclusion is not based on the date the condition arose.

#### **Lifetime and Annual Limits**

PPACA generally prohibits group health plans, and group and individual health insurance issuers, from imposing lifetime or annual limits on the dollar value of health benefits, effective for plan years beginning on or after **September 23, 2010**. Although annual limits are generally prohibited, "restricted annual limits" are permitted for essential health benefits for plan years beginning before January 1, 2014.



### *Restricted Annual Limits*

The interim final rules establish a three-year phased approach for restricted annual limits. Annual limits may not be less than the following amounts for plan years beginning before January 1, 2014:

- \$750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;
- \$1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and
- \$2 million for plan years beginning on or after September 23, 2012, but before January 1, 2014.

These are minimums for plan years; plans may use higher annual limits or impose no limits. The limits apply on an individual-by-individual basis, so that any annual limit on benefits applied to families cannot cause an individual to be denied the minimum annual benefit for the plan year.

The restricted annual limits are designed to ensure that individuals would have access to needed services with a minimal impact on premiums. However, they could affect limited benefit plans or "mini-med" plans. Therefore, the interim final rule provides for the establishment of a program for waiving the annual limit restrictions if they would cause a significant decrease in access to benefits or increase in premiums. HHS is expected to issue guidance regarding these waivers in the near future.

### *Covered Plans*

The prohibition on lifetime and annual limits applies to both new and grandfathered group health plans. However, it does not apply to grandfathered individual policies. The restrictions on annual limits do not apply to account-based plans like health flexible spending arrangements (health FSAs), medical savings accounts (MSAs), health savings accounts (HSAs) and health reimbursement arrangements (HRAs).

### *Essential Health Benefits*

PPACA specifically provides that plans may impose annual or lifetime per-individual limits on specific covered benefits that are not "essential health benefits." Regulations still need to be issued on the definition of essential health benefits, but it will include at least the following general categories of items and services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services, including chronic disease management; and
- Pediatric services, including oral and vision care.

Until those regulations are issued, plans can use a good faith effort to comply with a reasonable interpretation of essential health benefits and must apply it consistently.



The interim final rules clarify that a plan can still exclude all benefits for a condition. Such an exclusion will not be considered an annual or lifetime limit as long as no benefits are provided for the condition.

#### *Enrollment Opportunities*

Under the interim final rules, individuals who reached a lifetime limit prior to the date the regulations are effective and are otherwise eligible for plan coverage must be given a notice that the lifetime limit no longer applies. They must also be permitted to re-enroll in the plan if they are no longer enrolled. The notices and enrollment opportunity must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Anyone who is eligible for the enrollment opportunity must be treated as a special enrollee who is eligible to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

#### **Rescissions**

PPACA and the interim final rules place limits on the ability of a group health plan, or group and individual health insurance issuer, to rescind health coverage. Effective for plan years beginning on or after **September 23, 2010**, coverage may be rescinded only in the case of fraud or intentional misrepresentation of a material fact. Fraud may include an omission of relevant facts. This standard applies to all rescissions, whether in the group or individual market, and whether the coverage is insured or self-funded. If a state law is more protective of individuals than the federal law, the state law will continue to apply.

For purposes of the interim final rule, a rescission is a cancellation or discontinuation of coverage that has a retroactive effect. For example, a cancellation that treats a policy as void from the time of enrollment is a rescission. Prospective cancellations and retroactive cancellations due to a failure to pay required premiums would not be considered rescissions.

The prohibition on rescissions applies whether the rescission applies to an individual, an individual within a family, or an entire group of individuals. The rules on rescissions also apply to representations made by the individual or a person seeking coverage on behalf of the individual, such as the plan sponsor.

In addition to setting federal requirements for rescissions, PPACA adds a new advance notice requirement when coverage is rescinded where still permissible. Group health plans and group health insurance issuers must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded. This 30-day period will provide individuals and plan sponsors with an opportunity to contest the rescission or look for alternative coverage.

The rules regarding rescission and advance notice apply to all grandfathered health plans.

#### **Patient Protections**

PPACA imposes three new requirements on group health plans and group or individual health insurance coverage that are referred to as "patient protections." These patient protections relate to the choice of a health care professional and benefits for emergency services and are effective for plan years beginning on or after **September 23, 2010**. They do not apply to grandfathered plans. The rules regarding choice of health care professional apply only to plans that have a network of providers.



### *Choice of Primary Care Provider*

If a group health plan, or group or individual health insurer, requires a participant to designate a primary care provider, the participant must be able to choose any participating primary care provider who is able to accept the participant as a patient. This rule includes a pediatrician as the primary care provider for a child. The plan must provide a notice informing each participant of the plan's terms regarding primary care provider designation. The notice should be included in the plan's summary plan description. The interim final rules include model language for this notice.

### *OB/GYN Care*

Plans that provide coverage for obstetrical and/or gynecological care (ob/gyn care) and require the patient to designate an in-network primary care provider may not require preauthorization or referral for a female participant seeking such care. The plan must inform each participant of these rules and should include the notice in its summary plan description. Model language is included in the interim final rules. A plan may still require the ob/gyn provider to follow any policies or procedures regarding referrals, prior authorization for treatments and the provision of series.

### *Emergency Services*

PPACA places additional requirements on plans and health insurance issuers that provide hospital emergency room benefits. Plans and issuers must provide those benefits without requiring prior authorization and without regard to whether the provider is an in-network provider.

Also, the plan or issuer may not impose requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network emergency services. Cost sharing requirements, such as copayments or coinsurance rates, imposed for out-of-network emergency services cannot exceed the cost-sharing requirements for in-network emergency services.

Despite this rule, out-of-network providers may balance bill patients, as long as the plan or issuer has paid a reasonable amount for the services. The interim final rules provide guidance on determining whether the amount paid is reasonable. Also, other cost-sharing requirements, such as deductibles or out-of-pocket maximums, may be imposed on out-of-network emergency services if the cost-sharing requirement generally applies to out-of-network benefits.

This **TBG** Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

Content © 2010 Zywave, Inc. Images © 2000 Getty Images, Inc. All rights reserved.

EAS 6/10



### **Patient Protection Model Disclosure**

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].



## **Interim Final Rules on New Appeals Process**

### **EXECUTIVE SUMMARY**

Under the Patient Protection and Affordable Care Act, a non-grandfathered group health plan must adopt an improved internal claims and appeal process and follow minimum requirements for external review. On July 23, 2010, interim final regulations were issued implementing these requirements (the Interim Final Rule). The appeals process rules are effective for **plan years beginning on or after September 23, 2010**. Comments on the Interim Final Rule are being accepted until September 21, 2010.

Key provisions of the Interim Final Rule include information on:

- How to comply with updated internal claims and appeals processes;
- Determining whether a state or federal external review process applies for appeals, along with guidance for each process; and
- Requirements for notices in connection with the appeals process.

This **TBG** Legislative Brief summarizes the new Interim Final Rule. Please read below for more detailed information. For a copy of the regulations, see [www.federalregister.gov/a/2010-18043](http://www.federalregister.gov/a/2010-18043).

### **SUMMARY OF THE INTERIM FINAL RULE**

#### **Internal Claims and Appeals Process for Group Health Plans**

Health care reform requires group health plans to implement an effective internal claims and appeals process. These plans, as well as health insurance issuers providing their health insurance coverage, must follow the Department of Labor's claims procedure rules for group health plans.<sup>1</sup>

In addition to the existing DOL claims procedure regulations, group health plans must follow a number of new requirements:

1. ***New Definition of "Adverse Benefit Determination."*** The definition of the term adverse benefit determination is found in the claims procedure regulations. It includes a denial, reduction, termination of, or failure to pay for (in whole or in part), a benefit under the plan. It includes decisions based on an individual's eligibility to participate in the plan, a benefit not being a covered benefit, imposition of an exclusion, or a benefit being experimental or not medically necessary. Denials can include both pre- and post-service claims.

The Interim Final Rule adds rescissions of coverage to the definition of the term adverse benefit determination. A rescission is a cancellation or discontinuation of coverage that has a retroactive effect. A cancellation because of a failure to timely pay premiums for coverage is not considered a rescission.

2. ***Expedited Notice for Urgent Care Claims.*** Under the Interim Final Rule, group health plans must notify claimants of a benefit determination involving an urgent care claim more quickly. The new deadline is as soon as possible, taking into account the medical circumstances, but not later than **24 hours** after the plan gets the claim. There is an exception to the deadline if the claimant does not provide enough information to the plan.

---

<sup>1</sup> [www.federalregister.gov/a/00-29766](http://www.federalregister.gov/a/00-29766)



The prior rule required the notice to be given within 72 hours. The change is attributable to faster decision-making capabilities, due to electronic communication.

3. **Full and Fair Review.** In addition to complying with the claims procedure regulations' existing requirements, group health plans must follow additional rules to make sure claimants receive a full and fair review. Specifically, the plan must give the claimant any new evidence related to the claim or new rationale for a decision, free of charge. It must be provided as soon as possible and early enough before the appeal deadline to let the claimant respond.
4. **Avoiding Conflicts of Interest.** Group health plans must make sure that all claims and appeals are decided in a way that avoids conflicts of interest. The decision method must be designed to ensure the independence and impartiality of the decision-makers. The decision to hire a person involved in deciding claims or appeals must not be made based on the likelihood that they will support a denial of benefits. For example, a plan cannot provide bonuses based on the number of denials made by a claims adjudicator. Also, a plan cannot hire a medical expert based on his or her reputation for outcomes in contested cases, rather than his or her professional qualifications.
5. **Notice.** The Interim Final Rule provides new standards regarding notice to enrollees. Group health plans must provide notices required by the claims procedure regulations in a culturally and linguistically appropriate manner. See the section entitled "Required Notices" below for a discussion of the culturally and linguistically appropriate standards. The notices must also include the following additional content:
  - Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code and its meaning, and the treatment code and its meaning;
  - The reason for the denial must include the denial code and its meaning, as well as any standard used in denying the claim;
  - A description of available internal appeals and external review processes, including information about how to initiate an appeal; and
  - Contact information for any applicable office of health insurance consumer assistance to assist individuals with the internal claims and appeal and external review processes.
6. **Deemed Exhaustion of Internal Claims and Appeals Processes.** If a plan fails to comply with these rules, the claimant will be deemed to have exhausted the plan's internal claims and appeals process, even if the plan claims that it substantially complied with the requirements. That means that the claimant is free to pursue other remedies, such as external review or a lawsuit.
7. **Continued Coverage Pending Outcome of Internal Appeals.** Under the new rules, a plan must continue to provide coverage to the claimant until an internal appeal is resolved. Generally, this means that plans may not reduce or terminate an ongoing course of treatment without advance notice and an opportunity for advance review. Also, anyone in an urgent care situation or receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeal.

### External Review Standards

Group health plans must comply with either a state external review process or the federal external review process. The Interim Final Rule provides guidance on which process must be followed.



### ***State Standards for External Review***

If a state external review process that applies to and is binding on an insurance issuer includes the consumer protections in the NAIC Uniform Model Act in place on July 23, 2010, then the issuer must comply with that state external review process. In that case, where benefits under a group health plan are provided through health insurance coverage, the issuer must provide the external review process and the group health plan itself is not obligated to do so. Some self-insured group health plans may be subject to the state external review process if they are not subject to ERISA preemption.

Any plan or issuer that is not subject to a state external review process must comply with the federal external review process. A plan or issuer will be subject to the federal process if there is not state external review process or if the state external review process does not meet the minimum requirements of the NAIC Uniform Model Act.

The Department of Health and Human Services will determine whether a state external review process meets the minimum requirements. HHS will also provide a transition period for plan years beginning before July 1, 2011, where existing state external review processes will be treated as meeting the minimum requirements. This transition period will give states the opportunity to review and amend their processes. For plan years beginning on or after July 1, 2011, the federal external review process will apply unless HHS determines that the state process meets the minimum standards.

### ***Federal External Review Process***

The health care reform law requires a federal external review process to be established. The Interim Final Rule does not establish that process, but it does describe the standards that will be included. Plans or issuers that are not subject to a state external review process will have to follow the federal process. For an insured group health plan, if either the issuer or the plan complies with the federal process, then the obligation is satisfied for both the plan and the issuer.

The federal external review process will apply to most adverse benefit determinations or final internal adverse benefit determinations, including rescissions. However, it will not apply to denials based on a participant or beneficiary's ineligibility for the plan.

The standards to be issued for the federal external review process will include procedures for initiating and conducting the review, an expedited external review process for certain claims, additional consumer protections for claims involving experimental or investigational treatment, and additional notices and disclosures to claimants.

### ***Required Notices***

Notices of available internal claims and appeals and external review processes must be provided in a culturally and linguistically appropriate manner. This means providing notices in a non-English language if certain thresholds are met for the number of people who are literate in the same non-English language.

For a group health plan that covers fewer than 100 participants at the beginning of the plan year, the threshold is 25 percent of all plan participants being literate in only the same non-English language. For a plan that covers 100 or more participants, it is the lesser of (a) 500 participants, or (b) 10 percent of all plan participants.

If an applicable threshold is met, the notice must be provided in the non-English language upon request. In addition, the plan or issuer must include a statement in the English version of all notices offering the notice in the non-English language. The statement must be prominently displayed in the



non-English language. Once a request has been made by a claimant, all future notices to that claimant must be provided in the non-English language. Also, if the plan or issuer has a customer assistance process that answers questions or gives assistance with filing claims and appeals (such as a telephone hotline), the assistance must be provided in the non-English language.

This **TBG** Legislative Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

Content © 2010 Zywave, Inc. Images © 2000 Getty Images, Inc. All rights reserved.

EAS 7/10



**Appeals Process**

**Date of Notice:  
Name of Plan  
Address**

**Telephone/Fax  
Website/Email Address**

**This document contains important information that you should retain for your records.**

This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the next page for information about your appeal rights).

**Case Details:**

<b>Name:</b>	<b>ID Number:</b>
<b>Claim #:</b>	<b>Date of Service:</b>
<b>Provider:</b>	

**Reason for Denial (in whole or in part):**

<b>Amt. Charged</b>	<b>Allowed Amt.</b>	<b>Other Insurance</b>	<b>Deductible</b>	<b>Co-pay</b>	<b>Coinsurance</b>	<b>Other Amts. Not Covered</b>	<b>Amt. Paid</b>
<b>YTD Credit toward Deductible:</b>			<b>YTD Credit toward Out-of-Pocket Maximum:</b>				
<b>Diagnosis:</b>							
<b>Diagnostic Codes:</b>				<b>Requested Service(s)/ Treatment Code:</b>			
<b>Treatment Category (Subcategory):</b>				<b>Denial Codes:</b>			

*[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]*

**Explanation of Basis for Determination:**

*If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.*



**Important Information about Your Appeal Rights**

**What if I need help understanding this denial?** Contact us at [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

**What if I don't agree with this decision?** You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

**How do I file an appeal?** Detach and send in the bottom of this form within [insert timeframe, for example, X days from the date of this notice]. [If electronic notice, insert alternate submission instructions.]

**What if my situation is urgent?** If your situation meets the definition of urgent under the law, your review will be conducted within 24 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by [insert instructions for filing internal appeals (and, if applicable, simultaneous external review)].

**Who may file an appeal?** You or someone you name to act for you (your authorized representative) may file an

appeal. [Insert information on how to designate an authorized representative.]

**Can I provide additional information about my claim?** Yes, you may supply additional information. [Insert any applicable procedures for submission of additional information.]

**Can I request copies of information relevant to my claim?** Yes, you may request copies (free of charge) by contacting us at [insert contact information].

**What happens next?** If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

**Other resources to help you:** For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). [Insert, if applicable in your state: Additionally, a consumer assistance program may be able to assist you at [insert contact information].]

---

**Appeal Filing Form**

[Insert Name and ID Number]  
[Insert Patient Name]

[Insert Claim #]

Detach this form and send to: [Insert name and contact information]

**NAME OF PERSON FILING APPEAL:**

Covered person     Patient   

---

Authorized Representative



## **Preventive Care Coverage Guidelines Issued**

### **EXECUTIVE SUMMARY**

The Patient Protection and Affordable Care Act requires new health plans to cover preventive health services without imposing cost-sharing requirements for the services. On July 14, 2010, the Departments of Health and Human Services (HHS), Labor and Treasury issued interim final rules relating to coverage of preventive services. This requirement is generally effective for **plan years beginning on or after September 23, 2010**. It does not apply to grandfathered health plans.

Highlights of the regulations include:

- An explanation of the recommended preventive services that must be covered without cost-sharing requirements;
- Clarification regarding cost-sharing that may be imposed when preventive services are provided during an office visit; and
- Confirmation that cost-sharing can be imposed for out-of-network services.

This **TBG** Legislative Brief summarizes the new interim final rules. The rules are available at <http://edocket.access.gpo.gov/2010/pdf/2010-17242.pdf>.

### **SUMMARY OF THE REGULATIONS**

#### **Coverage of Preventive Services**

The interim final rules address the requirement that new (i.e., non-grandfathered) health plans cover certain recommended preventive services and eliminate cost-sharing requirements for such services. For plan years beginning on or after September 23, 2010, new group health plans must cover certain preventive services and may not charge copayments, coinsurance or deductibles for these services when delivered by a network provider.

The recommended preventive services covered by these requirements are:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA, which are to be developed by August 1, 2011.

These recommended preventive services include screening for a number of conditions, as well as counseling for various health-related issues. The complete list of recommended preventive services that must be covered can be found at [www.HealthCare.gov/center/regulations/prevention.html](http://www.HealthCare.gov/center/regulations/prevention.html).



## Office Visits

The interim final rules clarify the cost-sharing requirements when a recommended preventive service is provided during an office visit. Whether cost-sharing requirements may be imposed will depend on: (a) whether the preventive service is billed or tracked separately, and (b) whether the preventive service is the primary purpose of the office visit. Cost-sharing is permitted only if:

- The recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit; or
- The recommended preventive service is not billed separately from the office visit and the primary purpose of the office visit is not to obtain the recommended preventive service.

Cost-sharing requirements are not allowed in cases where the recommended preventive service is not billed separately, but it is the primary purpose of the office visit.

**Example.** An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is given a cholesterol screening (a recommended preventive service). The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test. The plan may not impose any cost-sharing requirements with respect to the laboratory work. Because the office visit is billed separately from the cholesterol test, the plan may impose cost-sharing requirements for the office visit.

**Example.** An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening (a recommended preventive service). The provider bills the plan for an office visit. The blood pressure screening was not the primary purpose of the visit. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

**Example.** A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam (a recommended preventive service). During the office visit, the child receives additional items and services that are not recommended preventive services. The provider bills the plan for an office visit. The recommended preventive service was not billed as a separate charge and was the primary purpose of the visit. Therefore, the plan may not impose a cost-sharing requirement for the office visit.

## Additional Clarifications

The regulations make clear that plans may continue to impose cost-sharing requirements on preventive services that employees receive from out-of-network providers. Also, plans may use reasonable medical management techniques to determine the frequency, method, treatment or setting for preventive services, as long as they are not specified in the recommendation or guideline.

This **TBG** Legislative Update is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

Content © 2010 Zywave, Inc. Images © 2000 Getty Images, Inc. All rights reserved.

EAS 7/10



## Changes to Health Accounts

### EXECUTIVE SUMMARY

The health care reform law, which consists of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA), makes some significant changes to accounts such as health flexible spending accounts (health FSAs) and health savings accounts (HSAs). These include:

- Reimbursement permitted for medicine or a drug only with a prescription (except for insulin).
- Contributions to health FSAs limited to \$2,500 per year, subject to cost-of-living increases.
- Increased tax on withdrawals from HSAs and Archer MSAs not used for medical expenses.

This **TBG** Legislative Brief describes the new rules related to these accounts and when the changes take effect. Please read below for more information and contact **TBG** with any questions.

### EXPLANATION OF CHANGES

#### ***Limits on Reimbursement of Over-the-Counter Medications***

The health care reform law has revised the definition of "qualified medical expenses" for purposes of reimbursement from health FSAs and health reimbursement arrangements (HRAs), and distributions from Archer medical savings accounts (Archer MSAs) and HSAs. The new definition is consistent with the definition used for the itemized tax deduction.

Under the new definition, qualified medical expenses include amounts paid for medicines or drugs **only if the medicine or drug is a prescribed drug** (determined without regard to whether the drug is available without a prescription) or is insulin.

This means that health FSAs and HRAs may not reimburse the cost of over-the-counter medications that do not have a prescription. Also, distributions from Archer MSAs and HSAs used to pay for over-the-counter medications without a prescription will be taxable and subject to penalties. However, amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.

The limits on over-the-counter medications for health FSAs and HRAs are effective for expenses incurred with respect to **taxable years beginning after December 31, 2010**. For HSAs and Archer MSAs, the limits are effective for amounts paid with respect to **taxable years beginning after December 31, 2010**.



### ***Limits on Health FSA Contributions***

Many employers choose to limit the amount that employees may contribute to a health FSA each year, but there is no federal limit on contributions. However, beginning in 2013, a health FSA offered through a cafeteria plan will have to limit the amount of salary reduction contributions that employees can make. Effective for **taxable years beginning after December 31, 2012**, employees may not elect to contribute more than **\$2,500 per year** to a health FSA. This amount will increase in future years to reflect cost-of-living increases.

### ***Increased Tax on Withdrawals from HSAs and Archer MSAs***

Participants in HSAs and Archer MSAs may withdraw funds from those accounts either to pay for qualified medical expenses or to use for other purposes. However, only withdrawals used to pay for qualified medical expenses are tax-free. If the funds are used for other purposes, the withdrawal becomes taxable and subject to penalties.

The health care reform law increases the additional tax on HSA distributions prior to age 65 that are not used for qualified medical expenses from 10 to **20 percent**. The additional tax for Archer MSA distributions not used for qualified medical expenses increases from 15 to **20 percent**. The increased taxes apply to distributions from these accounts made after **December 31, 2010**.

### **LEGISLATIVE REFERENCES**

For more information on these topics, see the following sections of the health care reform legislation:

- Limits on Reimbursement of Over-the-Counter Medications: **PPACA §9003**
- Limits on Health FSA Contributions: **PPACA §9005, §10902; HCERA §1403**
- Increased Tax on Withdrawals from HSAs and Archer MSAs: **PPACA §9004**

*This **TBG** Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.*

Content © 2010 Zywave, Inc. Images © 2000 Getty Images, Inc. All rights reserved.

ES 4/10



**Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity**

Plans and issuers are required to give written notice that the lifetime limit on the dollar value of all benefits no longer applies and that an individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan or issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

These notices may be provided to an employee on behalf of the employee's dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

The following model language can be used to satisfy the notice requirement:

The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].