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Regulations May Require Benefit Review

By Mark A. Amadeo, Esq.

July saw the promulgation of two regulations implementing the health reform legislation, as well as a long-awaited U.S. Department of Labor regulation on disclosure of fees by pension plan service providers, all of which are highlighted in this issue. The two new health reform regulations are, in fact, the latest in a wave of regulations under the Patient Protection & Affordable Care Act (PPACA) since the legislation passed early this year. The latest health plan regulations are generally effective in 2010 and 2011 plan years. Consequently, plan sponsors, administrators, and fiduciaries may need to make quick decisions to implement requirements under the regulations and update health plan documents and communications to participants and beneficiaries. The recent fee disclosure regulations similarly should prompt plan fiduciaries to review their existing agreements with service providers to ensure that they describe accurately the services provided in return for the charges to the plan, and impel them to examine the disclosed fees in light of those covered services.

DOL Issues Regulation On Fee Disclosures

By Mark A. Amadeo, Esq.

Last month, the U.S. Department of Labor issued its long-awaited final regulation on fee disclosures by retirement plan service providers. The regulation applies to defined benefit and defined contribution plans that are subject to ERISA, but does not apply to IRAs, SEPs, and SIMPLEs. The regulation also does not apply to welfare plans, which will be addressed in future regulations. The rule is effective on July 16, 2011 and the comment period closes on August 30, 2010. The final regulation can be found at http://edocket.access.gpo.gov/2010/pdf/2010-16768.pdf.

By way of background, an arrangement between a plan service provider and a plan generally is a prohibited transaction under ERISA unless the arrangement complies with certain criteria:

- The contract is reasonable.

- The services are necessary for the establishment or operation of the plan.
- No more than reasonable compensation is paid for the services.

In order for a contract to be reasonable, the final interim regulation requires a "covered service provider" to make certain disclosures to a "responsible plan fiduciary" — i.e., a fiduciary with authority to cause a plan to enter into, or extend or renew, a contract or arrangement for services to the plan. A "covered service provider" for purposes of the regulation is a service provider that enters into a contract or arrangement with a plan and reasonably expects to receive $1000 or more in compensation for providing one or more of the following services:

- Services as a plan fiduciary or registered investment advisor.
- Services for recordkeeping or as a broker that are provided to an individual account plan (e.g., a 401(k) plan) that permits participants to direct investments of their accounts, if one or more of the investment alternatives is made available in connection with the brokerage or recordkeeping services.
- Appraisal, banking, consulting (*i.e.*, consulting related to the development or implementation of investment policies or objectives, or the selection or monitoring of service providers or plan investments), custodial, insurance, investment advisory (for plan or participants), legal, recordkeeping, securities or other investment brokerage, third party administration, or valuation services provided to the covered plan, for which the covered service provider or an affiliate or subcontractor reasonably expects to receive indirect compensation.

Required Initial Disclosures

The interim final regulation requires a covered service provider to disclose the following information to a responsible fiduciary in writing:

- A description of fiduciary services being provided under the contract or arrangement.
- If applicable, a statement that the covered service provider, affiliate, or subcontractor will provide or reasonably expects to provide, services directly to the plan or plan asset investment vehicle as a fiduciary.
- If applicable, a statement that the covered service provider, affiliate or subcontractor will provide or reasonably expects to provide services directly to the plan as a registered investment advisor.
- A description of all direct compensation, either in the aggregate or by service, that the covered service provider, affiliate or subcontractor reasonably expects to receive in connection with the services.
- A description of all indirect compensation that the covered service provider, affiliate, or subcontractor reasonably expects to receive in connection with the services, and identification of the services for which the indirect compensation will be received and of the payer of the indirect compensation.
- A description of any compensation that will be paid among a covered service provider, its affiliates, and subcontractors, in connection with services if compensation is set on a transactional basis (e.g., commissions, soft dollars, finder's fees) or is charged directly against the covered plan's investment and reflected in the net value of the investment (e.g., 12b-1 fees), including identification of the

services for which such compensation will be paid and of the payers and recipients of the compensation.

- A description of any compensation that the covered service provider, affiliate, or subcontractor reasonably expects to receive in connection with the termination of the contract or arrangement and how prepaid amounts will be calculated and refunded upon termination.

- A description of the manner in which the compensation will be received, such as whether the covered plan will be billed or the compensation will be deducted directly from the covered plan's account(s) or investments.

Disclosures of Recordkeeping Services

If recordkeeping or brokerage services will be provided to a covered plan, the interim final regulation also requires a covered service provider, affiliate or subcontractor to provide a description of all direct or indirect compensation reasonably expected to be received in connection with such services.

If the covered service provider reasonably expects to provide recordkeeping services, in whole or in part, without explicit compensation for such recordkeeping services, or if compensation for recordkeeping services is offset or rebated based on other compensation received by the covered service provider, its affiliate, or its subcontractor, the service provider must provide a reasonable and good faith estimate of the cost of such recordkeeping services, including an explanation of the methodology and assumptions used to prepare the estimate and a detailed description of the recordkeeping services that will be provided to the covered plan.

Investment-Related Disclosures

A covered service provider that is a fiduciary with respect to an investment vehicle in which the covered plan has a direct equity investment must provide the following information: (i) a description of any compensation that will be charged directly against the amount invested in connection with the acquisition, sale, transfer of, or withdrawal from the investment contract, product, or entity (e.g., sales loads, sales charges, deferred sales charges, redemption fees, surrender charges, exchange fees, account fees, and purchase fees); (ii) a description of the annual operating expenses (e.g., expense ratio) if the return is not fixed; and (iii) a description of any ongoing expenses in addition to annual operating expenses (e.g., wrap fees, mortality and expense fees).

Recordkeepers and brokers that make available investment alternatives for participant-directed individual account plans must also provide the same investment related compensation information. This information must be provided with respect to each designated investment alternative for which recordkeeping or brokerage services will be provided.

Timing of Required Initial Disclosures and Changes in Terms

A covered service provider generally must provide the "Required Initial Disclosures" described above to a responsible plan fiduciary reasonably in advance of the date the contract or arrangement is entered into, and extended or renewed. A covered service provider must disclose a change in the information previously provided in an initial disclosure as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider's control, in which case the information must be disclosed as soon as practicable.

Ongoing Disclosure and Errors

A covered service provider must provide to a responsible plan fiduciary, upon request, any other information relating to the compensation received by the service provider that is required to be disclosed for the plan to comply with the reporting and disclosure requirements of Title I of ERISA. A service provider must disclose the requested information not later than 30 days following receipt of a written request from the fiduciary or covered plan administrator, unless disclosure is precluded due to extraordinary circumstances beyond the provider's control, in which case, the information must be disclosed as soon as practicable.

A contract or arrangement will not fail to be reasonable under the regulation solely because the service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the required information, as long as the provider discloses the correct information as soon as practicable, but no later than 30 days from the date the error or omission becomes known to the service provider.

Health Benefit Claims Process Subject To New Requirements

By Mark A. Amadeo, Esq.

On July 23, 2010, the Departments of Labor, Health and Human Services, and Treasury published the latest regulation implementing rules under the Patient Protection and Affordable Care Act (PPACA). The July 23 interim final regulation imposes new requirements on the internal claims and appeal processes and the external review processes of group health plans and group health insurance issuers. The regulation does not apply to grandfathered health plans. The interim final is effective on September 21, 2010, and applies to plan years beginning on or after September 23, 2010. Comments are due September 21, 2010. The regulation can be found at http://edocket.access.gpo.gov/2010/pdf/2010-18043.pdf.

Internal Review

The interim final regulation imposes six new requirements on internal review procedures for health benefit claims, in addition to those under the current regulatory framework.

First, the interim final regulation clarifies that rescissions of benefit coverage are included in the definition of an "adverse benefit determination," which, in turn, is subject to the internal and external review requirements.

Second, with regard to urgent care claims, a group health plan must notify a claimant of a benefit determination (whether adverse or not) as soon as possible taking into account medical exigencies, but no later than 24 hours after the receipt of the claim, unless the claimant fails to provide sufficient information to determine whether benefits are covered.

Third, a plan must provide a claimant, free of charge, with new or additional evidence considered, relied upon, or generated by the group health plan in connection with a claim. The evidence must be provided as soon as possible and sufficiently in advance of the date on which notice of the adverse decision must be issued so that a claimant has an opportunity to respond before the date a decision is due. In addition, before a plan issues an adverse benefit decision based on a new or additional rationale, a claimant must be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of the adverse decision must be issued, again, so that a claimant has an opportunity to respond before the date the decision is due.

Fourth, claims and appeals must be adjudicated in a manner that ensures the independence and impartiality of the person making the decision on a claim. Therefore, decisions on hiring, compensation,

termination, promotion, or similar matters cannot be made based on the likelihood that a person will support a benefit denial. For example, a plan cannot provide bonuses based on the number of claims denials and cannot hire a medical expert based on the expert's reputation for outcomes in contested cases.

Fifth, the content of notices to claimants must satisfy new standards. Notices must be provided "in a culturally and linguistically appropriate manner." A plan satisfies this standard if, under specific circumstances, notices are provided in a non-English language. In the group market in which a plan covers fewer than 100 participants, this requirement is triggered when 25% of participants are literate only in the same non-English language. For a group plan that covers 100 or more participants, this requirement is triggered when the lesser of 500 participants, or 10% of all plan participants speak only the same non-English language. Notices of adverse benefit determination also must include information sufficient for an individual to identify the claim involved. This requirement is met if the notice includes the date of service, the health care provider, the claim amount, and the diagnosis code, treatment code, and denial code, as well as the meanings of these codes. The notice also must include an explanation of the standards used to deny the claim. Lastly, the notice also must describe available internal appeals and external review processes and must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Sixth, if a plan fails to adhere to all requirements for internal claims and appeals, a claimant will be "deemed to have exhausted the internal claims and appeals process," regardless of whether the plan asserts that its noncompliance was an error or *de mininis*. Consequently, upon the plan's failure, a claimant may immediately initiate an external review and pursue any available remedies under applicable law, such as judicial review.

External Review

The interim final regulation requires group health plans to comply with either a state external review process or a federal external review process and provides a basis for determining when federal or state external review processes apply. For health insurance coverage, if a state external review process that applies to an issuer includes at least certain consumer protections contained in the Model Act promulgated by the National Association of Insurance Commissioners (NAIC), then a group health insurance issuer must comply with the applicable state external review process and not with the federal external review process. The minimum NAIC consumer protections that must be contained in a state external review process include:

- External review that is based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Effective written notice to claimants of the right to an external review of adverse decisions.
- Relief from any internal exhaustion requirement when an issuer waives exhaustion, a claimant is deemed to have exhausted under applicable law, or a claimant has applied for expedited review at the same time the claimant has applied for expedited internal review.
- A requirement that an issuer pay for the cost of any external review by an independent review organization.
- A prohibition on a minimum dollar threshold for a claim to be eligible for external review.

- A period of at least four months in which a claimant may file a request for external review after receipt of notice of an adverse decision.

- A process of random selection of an independent review organization or a method of selection that ensures the independent review organization is independent and impartial, qualified to review the claim, approved by a nationally recognized accrediting organization, and has no conflict of interest.

- A requirement that a claimant be permitted to submit in writing additional information that must be considered by an independent review organization when conducting an external review and that a claimant be given notice of this right.

- A requirement that any decision on external review is binding on issuer and claimant except to the extent other remedies are available under federal and state law.

- A requirement that for a standard external review, an independent review organization will provide written notice of its decision to claimant and issuer within 45 days after the request for review; and a requirement that for an expedited external review request, notice of a decision will be provided as expeditiously as possible, but not later than 72 hours after the receipt of the request for external review.

- A requirement that an independent review organization maintains written records and makes them available upon request to the state.

- A requirement that health plan issuers include a description of the external review process in the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to claimants.

- Procedures for external review of adverse benefit determinations involving experimental or investigational treatment that are substantially similar to those under the NAIC Uniform Model Act.

If an existing state external review process does not contain these minimum requirements, the interim final regulation provides a transition period – through the first plan year beginning after July 1, 2011, during which plans are subject to the state external review. If a state has not updated its external review provisions after the transition period, plans will be subject to a federal external review process.

Federal External Review Process

An ERISA-covered self-insured group health plan is not required to comply with a state external review process, but must comply with a federal external review process. Similarly, if a group health plan or insurer is not subject to a state law or if a state external review process does not contain the minimum required NAIC protections, a plan will be required to provide a federal external review process that contains protections similar to the minimum NAIC protections applicable to the state external review process. The interim final regulation does not otherwise specify the requirements of a federal external review process, but notes that guidance will be issued “in the near future.”

New Regulation on Cost-Sharing For Preventative Care

By Mark A. Amadeo, Esq.

The U.S. Departments of Labor, Health and Human Services, and Treasury published another final interim regulation under the Patient Protection and Affordable Care Act (PPACA) on July 19, 2010. The July 19 regulation requires group health plans and health insurance issuers to cover certain preventative services without any cost-sharing for enrollees when provided by in-network providers. The rules do not apply to grandfathered health plans. The regulation is effective September 17, 2010, and is generally applicable for plan years beginning on or after September 23, 2010. Comments are due September 17, 2010. The regulation can be found at http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=24044.

Preventative Care

The final interim regulation sets forth four categories of preventative care that must be provided without cost-sharing (i.e., co-pays, co-insurance, or deductibles):

- 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 (Task Force) with respect to the individual involved.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual Involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

Office Visits

The interim final regulation also provides rules and examples on how the cost-sharing restrictions apply when preventative services are provided during office visits. Specifically, the interim rule states that if a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. If a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit. If a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit. The reference to tracking individual encounter data was included to provide guidance with respect to plans and issuers that use capitation or similar payment arrangements that do not bill individually for items and services.

The interim final regulation provides four examples to illustrate the “office visit” provisions. In the first example, an individual receives a cholesterol screening test, a recommended preventive service, during

a routine office visit. The health provider bills the plan for an office visit and separately for the laboratory work of the cholesterol screening. Under the interim final regulation, the plan or issuer may impose cost-sharing requirements for the office visit because the recommended preventive service is billed as a separate charge, but may not impose cost-sharing requirements with respect to the separately billed laboratory work for the cholesterol screening test.

The second example includes the same facts as the first, except that as a result of the cholesterol screening, the individual is diagnosed with hyperlipidemia and is prescribed a treatment that is not included in the Task Force recommendations. Because the treatment is not included in the recommendations, the plan is not prohibited from imposing cost-sharing requirements on the treatment.

In a third 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, which for the individual is recommended under the Task Force guidelines. The provider does not bill the blood pressure screening as a separate charge. Since the primary purpose of the office visit was the abdominal pain and not the blood pressure screening, the plan may impose cost-sharing with respect to the office visit.

In the final example, a child covered by a group plan visits an in-network pediatrician for an annual physical recommended under HRSA guidelines, but during the visit receives additional services not covered under the HRSA guidelines that are not billed separately. Since the primary purpose of the visit is for services recommended under HRSA guidelines, the plan may not impose cost-sharing with respect to the office visit.

ABOUT THE LAW FIRM:

The Amadeo Law Firm, PLLC, is a litigation and consultation boutique with offices in Frederick, MD & Washington, DC. The firm represents clients in commercial, employment, employee benefit, and government contracting matters.

The laws governing employee health and pension benefits are often complex and evolving. Employers, plan sponsors, and plan fiduciaries may need to seek consultation to ensure compliance with latest rules and applicable regulations.

The Employee Benefits Practice of the Amadeo Law Firm, PLLC, monitors employee benefit laws and regulations and provides sophisticated advice to employers, plan sponsors, and plan fiduciaries. The firm helps clients achieve workforce management goals related to providing employee benefits while also enabling them to devote their attentions to what matters most: their businesses.

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