Health Care Reform and Claims and Appeals Procedures
September 14, 2010

Q1. How will health care reform impact the claims and appeals procedures CVS Caremark currently uses to administer pharmacy benefit programs?

- Current Standard. In providing prior authorization (PA), claims and appeals services under its PBM contracts, CVS Caremark follows the U.S. Department of Labor's claims and appeals regulations promulgated under Section 503 of ERISA ("503 Regulations"). The 503 Regulations set forth the minimum requirements for claims and appeals procedures to comply with ERISA.

    - The only exceptions are situations where a state has (i) issued stricter requirements that apply to health plan clients or (ii) adopted alternative procedures that apply to government plans or church plans that are not subject to ERISA.

- New Requirements. The Patient Protection and Affordable Care Act ("ACA") imposes a number of new requirements relating to claims and appeals processing and external review that will need to be incorporated into the procedures currently utilized by CVS Caremark in providing PA, claims and appeals services to its clients. The rew requirements under the ACA include:

    - Requiring government plans and church plans that are not otherwise subject to ERISA to comply with the 503 Regulations and with the new claims, appeals and external review requirements of ACA.

    - Shortening the period in which plans must make a benefit determination on urgent care claims from 72 to 24 hours.

    - Giving claimants the right to review the claim file and present evidence and testimony as part of the internal claims and appeals process.

    - In any case where new or additional information about the claim is considered, relied upon, or generated–

        - Providing the new information to the claimant free of charge while the appeal is under consideration and with enough time to give the claimant an opportunity to respond before the deadline under the 503 Regulations for making a determination on appeal[1]; and

        - Where a determination is based on new or additional information, providing the rationale for the determination to the claimant free of charge with enough time to give the claimant an opportunity to respond before the deadline under the 503 Regulations for making a determination on appeal.

    - Requiring increased disclosure regarding benefit determinations, including:

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[1] Currently under the 503 Regulations, plans are only required to provide claimants with new information on request, rather than automatically. Additionally, curreny 503 Regulations limit a claimant's opportunity to respond.

    - Culturally and linguistically appropriate notices;
    - Information that allows the claimant to identify the specific claim that is the subject of the notice (including date of service, provider, claim amount, diagnosis code, treatment code, and explanations of the codes);
    - A specific reason for the denial that is tied to the diagnostic and treatment codes;
    - A description of any standard used in denying the claim and, in the final notice, a discussion of the decision; and
    - Information about the availability of and contact information for the applicable office for health insurance consumer assistance established under ACA to assist claimants with appeals.
  - Giving claimants the opportunity to seek external review or judicial review of claims determinations where plans do not "strictly" comply with the 503 Regulations and new ACA rules.
  - Requiring plans to establish procedures to avoid conflicts of interest and ensure that the people making claims decisions are independent and impartial.[2]
  - Making decisions about rescission of coverage subject to the 503 Regulations and provisions of ACA that deal with adverse benefit determinations.
  - Providing continued coverage pending the outcome of an internal appeal.
- Additional Requirements for Plans in the Individual Market. In addition to the requirements listed above, ACA imposes requirements specific to internal claims and appeals and external review for health plans in the individual market. These additional requirements include:
  - Expanding the scope of the internal claims and appeals process to cover initial eligibility determinations.
  - Requiring only level of internal appeals before a claimant may seek external review or judicial review (the 503 Regulations permit a second level of internal appeals for group health plans).
  - Maintaining records of all claims and notices associated with the internal claim and appeal process for at least six years.

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[2] For example, plans may not base hiring, compensation or termination decisions on claims denials. Plans may only retain an expert based on the expert's professional qualifications, and not the expert's reputation for outcomes in contested cases.

This information is intended to be general guidance and is not intended as legal advice.
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Q2: When do the ACA claims and appeals rules take effect?

The new ACA claims and appeals rules are effective for plan years starting on or after September 23, 2010. For example, for a group health plan that uses a calendar plan year, the new rules will be effective January 1, 2011. *Note the grandfather rule exception discussed below.*

Q3: Do the ACA claims and appeals rules apply to grandfathered plans?

The new ACA claims and appeals rules do not apply to grandfathered plans (i.e., health plans providing coverage to participants on March 23, 2010 that do not change terms related to benefits and cost-sharing). However, health plans can easily lose grandfathered status by making material changes to the plan. Interim final regulations under ACA provide that grandfathered status can be lost by (i) changing insurers or insurance policies, (ii) reducing the scope of plan benefits related to specific conditions, or (ii) increasing the share of plan costs paid by participants above certain permitted amounts (including increasing co-pays or fixed payment amounts). The interim final regulations requested comments on whether the following changes should also cause a loss of grandfather status: (i) changes in plan structure, (ii) changes in a provider network, (iii) formulary changes, and (iv) benefit design changes.

- Grandfathered ERISA plans must continue to comply with the 503 Regulations, but are not required to follow the new ACA claims and appeal requirements as long as they maintain grandfathered status. Insured ERISA plans also must continue to comply with stricter state law requirements imposed on insurers.

- Grandfathered government and church plan, if self-insured, are not required to comply with either the 503 Regulations or ACA claims and appeal requirements. Such plans may be subject to state law requirements, particularly if insured.

- Early indications are that many employers do not attribute significant value to grandfather status and will not forego plan design changes just to maintain the status. Thus, over time, most employer plans are expected to become subject to the 503 Regulations and the new ACA claims, appeals and external review requirements.

Q4: What are the ACA requirements for external review?

Health plan clients subject to state external review laws that as a minimum meet the consumer protection standards in the NAIC Uniform Model External Review Act will continue to be subject to such state laws and such laws may be extended by state action to cover government plans or church plans as well. Where the state law is deficient or where the client is a self-funded ERISA plan, new – yet to be promulgated – external review requirements modeled on the NAIC Model Act will apply. In order to give states the opportunity to bring their laws into compliance with the NAIC Model Act, existing state laws will be deemed compliant until plan or policy years beginning on or after July 1, 2011.

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Q5: What steps are CVS Caremark taking to address the ACA appeals requirements?

- CVS Caremark will be working with its clients to review current benefit notices and revise notices as necessary to meet new disclosure requirements.
- CVS Caremark will consider whether to offer ACA-compliant external review procedures.
- CVS Caremark will develop written procedures to avoid conflicts of interest and ensure the independence and impartiality of the people who make claims decisions.
- CVS Caremark will be establishing procedures to identify and distribute new or additional information considered during appeals to claimants.
- CVS Caremark will be taking other appropriate steps to address the ACA's claims and appeals requirements.

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