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Claims and Appeal Rules Significantly Modified for Non-grandfathered Health Plans Under New Regulations

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Overview

On July 22, 2010, three federal agencies published new regulations imposing new rules on non-grandfathered health plans, requiring such plans to significantly modify their claims procedures. The regulations impose new rules for a plan's current claims process and, at least in some situations, require external review by a third party – even for ERISA-covered plans. The new regulations contain some surprising requirements that will significantly impact plan sponsors, insurers and third party administrators ("TPAs").

Internal Claims and Appeals Processes

Currently, group health plans are subject to the internal claims and appeals processes set forth in the U.S. Department of Labor ("DOL") regulations. Although the DOL standards continue to apply, the new regulations broaden those standards in seven significant ways:

1. **Expanded Definition of "Adverse Benefit Determination:** The definition of an "adverse benefit determination" under the DOL's standards is expanded to include rescission of coverage. Currently, the DOL regulations define an "adverse benefit determination" as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment (for pre-service or post-service claims) that is based on:

    - a determination of an individual's eligibility to participate in a plan or health insurance coverage;
    - a determination that a benefit is not a covered benefit;
    - the imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
    - a determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

2. **Notification of Urgent Care Claim Determinations Shortened:** The plan or issuer must notify an urgent care claimant of its determination with respect to a claim within 24 hours after

receipt of the claim unless the claimant failed to provide sufficient information to process the claim. The current standard is 72 hours*. Note that the standard is not based upon business days. So, if an urgent care claim is received at 4:30 p.m. on a Friday, it appears a plan (or its insurer or TPA) must make a decision by 4:30 p.m. Saturday.*

3. **Additional Evidence Disclosure Requirements:** The plan or issuer must provide the claimant with any new or additional evidence which the plan or issuer considered, relied upon, or generated in connection with the claim, as well as any new or additional rationale, for an adverse benefit determination. The information must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date (e.g. generally 60 days following the plan or issuer's receipt of the claimant's request for review). These items must be provided free of charge. It appears the information must be provided automatically, regardless of whether the claimant files a request for this information.

4. **New Impartiality Requirements:** The plan or issuer must adjudicate claims and appeals in a manner designed to ensure the independence and impartiality of the persons involved in the decision. The regulations require that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. For example, the party making the decision cannot be compensated on the basis of the number of denied claims he or she makes in a given period.

***Action Item*: Plan sponsors should review their current appeal procedure.**

Example: Chief Financial Officer (“CFO”) on Appeals Committee. Many self-funded plans have a committee of employees deciding final appeals. Sometimes those committee members could, arguably, have a bias to deny claims. For example, the plan sponsor’s CFO could serve as a member of the committee. The CFO’s bonus may be tied to the plan sponsor’s net profit. High medical plan claims may reduce the plan sponsor’s net profit. The CFO’s compensation or bonus may be tied to keeping the plan sponsor’s net profit as high as possible. If so, a participant or beneficiary (or the DOL) may be able to claim that the CFO is not impartial. On the other hand, perhaps the CFO could argue that his or her vote is only one out of a committee and, therefore, the CFO does not necessarily control whether an appeal is approved or denied.

5. **New Notice Requirements:** The plan or issuer must ensure that notice of an adverse benefit determination describes:

    - the date of service;
    - health care provider;
    - claim amount (if applicable);
    - diagnosis, treatment, and denial codes (and the corresponding meanings of these codes);
    - a description of the plan's or issuer's standards used to deny the claim (e.g., if the claim was denied as not medically necessary, the denial notice must include a description of the medical necessity standard); and,
    - for a final internal adverse benefit determination, a discussion of the decision.

In addition, it appears that any notice issued on a benefit determination

(approving or denying) must include:

- a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- a description of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman available to assist enrollees with the internal claims and appeals and external review processes. *Note: It is not clear whether the consumer assistance or ombudsman provisions will apply to a self-funded, ERISA-covered plan.*

Plans and issuers must notify enrollees of its decisions in a culturally and linguistically appropriate manner. Thus, the plan may be required to translate its decision into a non-English language depending upon the number of participants in the plan and the percentage of those participants who are literate only in that same non-English language.

The DOL will release model notices in the near future.

6. **Continued Coverage:** Pending the outcome of an internal appeal, the plan or issuer must continue to provide continued coverage to the claimant. Therefore, benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

7. **Strict Compliance:** If the plan or issuer fails to "strictly" adhere to the six preceding requirements, the claimant will be deemed to have exhausted the internal claims and appeals process. The regulations reject lesser standards (such as whether a plan's failure to follow the rules constituted "substantial compliance" or whether an error was "de minimis"). **Failing to follow the claims procedure rules allows the claimant to initiate an external review or pursue any available remedies under applicable law (like judicial review).**

Potential Loss of Deferential Standard:

Unfortunately, the regulations then take the penalty one step further. The regulations state that, in this circumstance, a "claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary." Unfortunately, this phrase is not explained in the regulations but could mean that a court should not grant any discretion to the plan sponsor when it reviews the claim as part of a lawsuit which would be a very significant change. Under the claims procedure regulations, it is not unusual to have some de minimis failure (i.e., one that would fail the "strict compliance" standard). Often a minor failure has not hurt plan sponsors because it has not automatically caused a loss of deferential review. **Now it appears that a non-grandfathered health plan will lose this deferential review, making it significantly more likely that the plan will lose any lawsuit filed by the participant or beneficiary.**

External Review

Under the health care reform law, the Patient Protection and Affordable Care Act ("PPACA"), plans (other than grandfathered plans) are required to provide to participants both internal and external review of claims. Essentially, if a claim is not approved through the internal appeals process, the participant has the ability to seek an independent third party's decision regarding whether the claim should have been covered. **It appears that the third party's decision is binding upon the**

claimant and the plan or issuer, unless other remedies are available under state or federal law. This marks a substantial change for many employer health plans.

There are two types of external reviews: state and federal. Each of the external reviews are conducted by a third-party independent review organization. Under the regulations, the agencies will defer to the state external review process where it exists, legally applies to the plan, and where the state's review process meets the requirements of the consumer protections in the National Association of Insurance Commissioner's ("NAIC") Uniform Model Act in existence as of July 22, 2010. The regulations create a two-tier track: a "State" external review process and a "Federal" external review process. However, the regulations only provide details on the State external review process*. Note: The federal external review process will be detailed in further regulations.*

1. **State External Review:** The state's external review process will generally apply to insured group health plans and plans not subject to ERISA (e.g., nonfederal governmental programs, certain church plans) or subject to both state and federal law (e.g., multiple employer welfare arrangements). Health and Human Services ("HHS") will determine whether a state's external review process meets the requirements. There are several requirements for state external review processes, including:

    - there can be no minimum limit on the amount of the claim to be eligible for an external review (e.g., a $500 minimum claims threshold);
    - there must be a period of a least four months following the receipt of an adverse benefit determination or final adverse benefit determination to request review;
    - the issuer (or plan, presumably) is responsible for paying the cost of the independent review organization's review;
    - the state will randomly select the reviewing organization; and
    - the claimant has the ability to submit additional information (it is not clear that the plan or issuer will be permitted to respond).

2. **Time Period for State External Review:** HHS has provided a transition period during which state external review processes which do not currently meet the NAIC compliant review processes may be brought up to standard. The transition period applies to plan years beginning before July 1, 2011. During this period, a plan which is subject to an insufficient state review process and which complies with such state review process as it exists will be deemed to have complied with the external review process requirements. For plan years beginning on or after July 1, 2011, if the state has not brought its review process into compliance, the plan or issuer must utilize the federal external review process to ensure compliance with the regulations.

***Action Item*: Plans and issuers are required to provide notice to claimants of their rights in connection with an external review. It is not clear whether this notice requirement is satisfied by meeting the new notice requirements for a benefit denial discussed in the previous section.**

Federal External Review

Details about the new external review rules for ERISA-covered plans will be issued in the future. The agencies do indicate, however, that the rules will be similar to model rules adopted by NAIC.

Action Item: Plan sponsors with ERISA-covered plans should begin analyzing

the model rules for a preview of what the new rules will likely require.

Grandfathered Plans

Grandfathered plans do not have to comply with these new regulations. Therefore, it appears that grandfathered plans remain subject to the old standards. As a practical matter, plans, insurers and TPAs may simply choose to follow some of the new rules (e.g., urgent care review within 24 hours, not 72 hours) as a matter of administrative convenience. A change to voluntarily comply with PPACA's provisions will not cause the plan to lose grandfathered status.

Effective Date

The new rules are **effective for the first plan year beginning on or after September 23, 2010 (e.g., January 1, 2011 for a calendar year plan)**.

It is anticipated the agencies will release updated regulations at a later date, particularly to expand on the federal external review process. Consequently, these regulations are set to expire when such regulations are released on July 22, 2013.

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