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Health Care Reform Alert

August 11, 2010

New Claim and Appeal Procedures

On July 23, 2010, the Departments of the Treasury, Labor, and Health and Human Services jointly issued Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and External Review Processes Under the Affordable Care Act (IFRs). These IFRs build on the Department of Labor's (DOL) current claim regulations for internal claim and appeal procedures, but add additional requirements, including, for the first time, an external appeal procedure.

These IFRs are effective as of September 21, 2010, but will apply to employer-sponsored group health plans (GHPs) and health insurers for plan or policy years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar year plans or policies). For GHPs whose plan years begin on or after October 1, 2010 and before December 31, 2010, the effective date will be this year, and that does not leave much time.

These new requirements do not apply, however, to grandfathered plans (to review our other plan Alerts, click here *Health Care Reform: So Your Plan Is Grandfathered? What Does That Mean?* or *Health Care Reform: New Regulations Provide Guidance on Loss of Grandfathered Plan Status*), and avoiding these new claim and appeal requirements may provide a compelling reason to retain grandfathered plan status.

Internal Claim and Review Procedures

Even before the Affordable Care Act (ACA), health insurers providing insurance coverage to GHPs regulated under ERISA were arguably claim fiduciaries, because they made final claim determinations under those GHPs, and, as claims fiduciaries, were subject to the DOL's current claim and appeal regulations. These IFRs now clarify that such compliance is now mandatory for health insurers. Self-funded GHPs, and their third party administrators, have always had to comply with the DOL claim regulations.

In addition to requiring compliance with the current DOL claim regulations, the IFRs add six additional requirements:

- *Determinations Eligible for Internal Claim and Appeal Procedures* – The definition of adverse benefit determination is broadened to include rescissions of coverage, as defined under the ACA, and the regulations thereunder. Thus, an adverse benefit determination is a denial, reduction or termination of, or failure to provide or make payment for, a benefit based on a determination that: (1) a person is ineligible for coverage, (2) the benefit is not a covered benefit, (3) a plan limitation or exclusion applies, (4) a benefit is experimental, investigational or not medically necessary or appropriate, or (5) coverage has been rescinded (even if no specific benefit claim is at issue).

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- *Shorter Time for Urgent Care Claims* – The time period for notifying a claimant of an urgent care claim has been reduced from 72 hours to 24 hours.
- *Provide Advance Information and Opportunities to Respond* – The plan or insurer must provide the claimant, free of charge and, presumably, without the need for a specific request, any new or additional evidence considered, relied on or generated by the plan or insurer, as soon as possible and sufficiently before the determination is made, to provide a reasonable opportunity for the claimant to respond. If the plan or issuer seeks to deny a claim based on a new or additional rationale, the claimant must be informed of the new or additional rationale free of charge, and again, in sufficient time to allow the claimant to respond.
- *Impartial Decision-Makers* – The plan or insurer must ensure that all claims are adjudicated in an impartial manner — meaning that any decisions regarding the compensation, termination, promotion or similar employment action relating to a claim decision-maker cannot be based on a likelihood that the person will support a denial of benefits. Presumably, the Supreme Court's jurisprudence regarding conflicts of interest relating to claim adjudication will still apply generally.
- *Content and Language Requirements* – Notice of Adverse Benefit Determinations (Notice) must be provided in both English and another culturally and linguistically appropriate manner. For plans with fewer than 100 participants at the beginning of the plan year, the Notice must be provided in a non-English language in which at least 25% of the participants are literate. For plans with 100 or more participants at the beginning of the plan year, the Notice must be provided in a non-English language in which the lesser of 500 participants or 10% of all participants are literate. The English version of the Notice must include a prominent statement in the non-English language describing the availability of the Notice in that other language. Once a participant requests a non-English Notice, all future notices must be provided in that other language.
- The Notice also must include the following information: (1) the date of service, (2) the health care provider, (3) the claim amount, if applicable, (4) the diagnosis code (*e.g.*, the ICD-9, ICD-10 or DSM-IV code) and the meaning of these codes, (5) the reason or reasons for the adverse or final adverse determination, including any denial codes (such as CARC or RARC, if applicable) and the meaning of such codes, (6) a description of the standards, if any, used in denying the claim (*e.g.*, if a claim is denied for lack of medical necessity, the plan or policies standard for determining medical necessity must be included), (7) if the adverse determination is a final determination, a discussion of the decision (it is not clear exactly what this discussion should consist of or how extensive such a discussion must be), (8) a description of any available internal or external appeals procedures, and

information about how to initiate the appropriate procedure, and (9) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with internal appeals and external review procedures.

- *Effects of Failure to Comply* – If a plan or insurer fails to adhere strictly to all requirements, the claimant is deemed to have exhausted the internal claims and appeal processes, regardless of whether the plan or insurer has substantially complied with the requirements. Although the current DOL claim regulations have a similar provision, these IFRs are intended to impose a stricter standard and be more rigorously enforced.

Plans and insurers must also provide continuing coverage pending the outcome of the internal appeal process. Current DOL claim regulations prohibit plans and insurers from discontinuing coverage for ongoing courses of treatment without providing adequate notice and an opportunity for review. The IFRs require plans and insurers to continue coverage for the treatment for which the denial is being appealed, presumably until a final internal determination is made. Numerous questions remain unanswered. For example, where a denial is based on a lack of eligibility for plan benefits or a rescission of coverage, must all coverage be continued until a final determination has been made? If the denial is based on payment for a specific treatment or service not being a covered benefit, must coverage generally be continued, or must coverage be continued only for that treatment or service?

External Review Procedures

Currently, all but five states (North and South Dakota, Alabama, Mississippi and Nebraska) have some type of external appeals procedures, but the requirements vary greatly from state to state. The IFRs provide that health insurers and self-funded plans not regulated under ERISA (*i.e.*, government and church plans) must comply with the state-provided external review procedures, provided that these procedures, at a minimum, include the consumer protections found in the NAIC Uniform Health Care Carrier External Review Model Act in place on July 23, 2010 (NAIC Model Act). The preamble to the IFRs list 16 specific consumer protections in the NAIC Model Act. States have until July 1, 2011 to include the NAIC consumer protections into their external review statutes. Presumably, until then, insurers can meet this external review requirement by continuing to comply with the applicable state law currently in effect.

Michigan has an external review statute – the Patient's Right to Independent Review Act, P.L. 251 of 2000 (Michigan External Review Act). The Michigan External Review Act does not apply to self-funded plans. It provides for an external review through an

independent review organization (IRO) for claims involving medical judgment, and through the Insurance Commissioner for "purely contractual issues," but it does not contain all 16 consumer protections provided for in the NAIC Model Act and listed in the IFRs.

Plans and insurers that are not eligible to utilize state-law external review procedures – *i.e.*, self-funded GHPs regulated under ERISA – or that have state external review laws that do not incorporate the consumer protections of the NAIC Model Act must comply with federal external review procedures. Thus, if the Michigan legislature does not update the Michigan External Review Act to comply with all the consumer protections of the NAIC Model Act by July 1, 2011, then all insurers and all self-funded employer–sponsored GHPs, whether or not regulated under ERISA, must comply with the federal external review procedures.

- Unfortunately, these IFRs only describe the kinds of standards that will be incorporated into the federal external review process, but do not set forth the federal external review process itself. The IFRs did provide a list of standards that the federal external review procedures will address, and did state that details of the federal procedures will be set forth in future guidance. One specific item the IFRs did address, however, was to expressly provide that the federal external review procedure will not be available where the claim denial is based solely on lack of eligibility for coverage under the GHP.

Action Steps

Employers must determine whether to elect to have their GHPs (whether insured or self-funded) retain grandfathered status, even if only for some intermediate period while the external appeal requirements are finalized and clarified. An employer whose GHPs are fully insured will have to discuss with its insurer how the insurer intends to comply, and what will be the insurer's position if the employer elects to have its insured GHP retain grandfathered status. The IFRs make clear that if the insurer complies with these claim procedures, the GHP does not have any additional compliance requirements, so retaining grandfathered status may be less crucial for insured GHPs.

An employer who self-funds its GHP must also address the grandfathered status of their plans, and, if they choose to comply with these new claim and appeal regulations, to check with the GHP's third-party administrator as to its capacity to comply with these new requirements.

If you have any questions about these new claim and review regulations, or any other changes imposed by the ACA, please contact any of the Honigman attorneys listed on this Alert.