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EBEC (Employee Benefits / Executive Compensation) Law Update

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GUIDANCE RE CLAIMS, APPEALS AND EXTERNAL REVIEW UNDER AFFORDABLE CARE ACT - EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER 9/23/2010

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively the "Affordable Care Act") [1] adds § 2719 of the Public Health Service Act [2] requiring that group health plans or group and individual health insurers must follow new or revised procedures for claims, internal appeals and external review (with respect to health claims or coverage determination).

As discussed further below, this rule is effective for plan years beginning on or after September 23, 2010, although there is some transition relief (see below). In addition, grandfathered plans that were in effect on March 23, 2010 need not comply as long as they maintain grandfathered status.

Interim regulations describe changes to existing Department of Labor claims procedures regulations and set forth the requirements for State external reviews (based on the Model Uniform External Review Act). The DOL has issued model notices of initial determination, final determination and external review. A DOL technical release gives temporary guidance on the Federal external review process, which would apply to self-insured plans. HHS and other guidance give certain transition relief.

1. Provision Regarding Appeals Process in Affordable Care Act.

The Affordable Care Act provisions for claims, internal appeals and external review require:

(i) having an internal review process in accordance with the existing claims procedures regulations[3] but updated in accordance with new regulations;

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[1] www.ncsl.org/documents/health/ppaca-consolidated.pdf

[2] Codified at 42 USC § 300gg-19. See also, Internal Revenue Code § 9815(a) and ERISA § 715(a) as amended by the Patient Protection and Affordable Care Act § 1562(e) & (f).

[3] DOL Reg. § 2560.503-1.

(ii) with respect to insured plans, complying with applicable State external review process that includes the consumer protections set forth in the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act [4] (the "NAIC Uniform External Review Act"); or with respect to a self-insured plans or insured plans where the State has not established a satisfactory external review process, implementing an effective external review process that meets the minimum requirements established by the DOL;

(iii) providing notice to participants of internal appeals and external reviews and stating availability of office of health insurance consumer assistance or ombudsman to assist participants with the appeals process; and

(iv) allowing a participant to review their file, present evidence and testimony in the appeal and receive continued coverage pending the appeal.

2. Effective Date

These provisions regarding claims procedures and external review are generally effective for plan years beginning on or after September 23, 2010. See below regarding transition relief.

3. Only Applicable to Non-Grandfathered Plans; Grandfather Definition

Grandfathered plans that were in effect on March 23, 2010 (date of enactment of Patient Protection and Affordable Care Act) and continue to maintain grandfathered status need not comply with the new claims, appeal and external review requirements.

A plan will generally lose grandfathered status if any of the following occur:

(i) benefits for a particular condition are eliminated or substantially reduced,

(ii) co-insurance charges are increased,

(iii) deductibles or out-of-pocket limits are significantly increased,

(iv) office co-pay amounts are significantly increased,

(v) fixed dollar deductibles are significantly raised,

(v) significantly lower employer contributions towards premiums,

(vi) addition or lowering of annual limit or

(vii) change in insurer.[5]

- *Other Provisions Already Effective but only for Non-Grandfathered Plans*. Other provisions of the Affordable Care Act that become effective for plan years beginning on or after Sept. 23, 2010 *only if the*

[4] http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf

[5] See Interim Final Regulations, 75 Fed. Reg. 34537 (June 17, 2010), edocket.access.gpo.gov/2010/pdf/2010-14488.pdf Treas. Reg. § 54.9815–1251T(g); DOL Reg. § 2590.715–1251(g); 45 CFR § 147.140(g).

Allowing new employees to join the plan will not cause a loss of grandfather status, transferring employees to a new plan without different terms and without a bona-fide employment reason would cause loss of grandfather status. Treas. Reg. § 54.9815–1251T(b); DOL Reg. § 2590.715–1251(b); 45 CFR § 147.140(b).

plan is not grandfathered include: (i) coverage of preventive care without any deductibles; (ii) prohibition on discrimination in favor of highly-compensated individuals even for insured plans (Code § 105(h) expanded beyond just self-insured plans); (iii) right to select a participating primary care provider or pediatrician, and to see obstetrician without referral.

- *Other Provisions Already Effective even for Grandfathered Plans*. Provisions of the Affordable Care Act that become effective for plan years beginning on or after Sept. 23, 2010 *even for grandfathered plans* include: (i) prohibition on preexisting condition exclusion or discrimination based on health status for children under age 19; (ii) prohibition on rescissions after coverage begins except in the case of fraud or intentional misrepresentation; (iii) no lifetime limits on coverage; (iv) extension of dependent coverage until age 26.[6]

4. Interim Final Regulations on Internal Appeal and External State Review Process

The Treasury, DOL and HHS have issued interim final rules on the new claims, appeal and external review process.[7] The interim regulations are effective for plan years beginning on or after September 23, 2010.

Internal Claims and Appeals. With regards to the internal claims and appeals process, the following changes have been made to existing DOL claims procedures regulations:

(i) Adverse benefit determinations include rescission of coverage.

(ii) Urgent care claims must be responded to as soon as possible and in all events within 24 hours (no longer a 72 hour deadline).

(iii) The claimant must be provided, free of charge, with new evidence or new rationale used for the determination as soon as possible.

(iv) Claims and appeals must be made impartially, and decisions regarding hiring and compensation of the persons involved in making the decision must not be made based upon the likelihood that the individual will support the denial of benefits.

(v) Notice requirements for advance benefit determinations are expanded to require translation of the notice in certain cases, information sufficient to identify the claim involved including date, provider, claim amount, diagnosis code and treatment code and their meanings, and denial code and its meaning or the plan's standard in denying the claim.[8]

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[6] In addition, the temporary pre-existing condition insurance high risk pool has gone into effect 90 days after enactment of the Patient Protection and Affordable Care Act. Beginning January 1, 2011 flexible spending accounts limited to $2,500 per year.

Note that the above lists are not comprehensive.

[7] 75 Fed. Reg. 43,330 (July 23, 2010), www.gpo.gov/fdsys/pkg/FR-2010-07-23/pdf/2010-18043.pdf

The ERISA regulations apply to ERISA plans and insurers, the IRS regulations apply to the group health plans and insurers and the HHS regulations apply to insurers of individuals or groups. Under the interim regulations, the claims and appeals rules apply to group health plans or their insurers, but for external review of insured plans the insurer alone has the obligation.

[8] Treas. Reg. § 54.9815–2719T(b); DOL Reg. § 2590.715–2719(b); 45 CFR § 147.136(b).

- *Substantial Compliance Not Sufficient*. In contrast to some existing case-law, substantial compliance with the claims procedures will not be sufficient, and if the claims procedures are not strictly adhered to, the claimant may sue in court as if the internal review process was exhausted, and the standard of review by the court would be "de novo" rather than an arbitrary or capricious standard (under the *Firestone v. Bruch* Supreme Court case).

- *Delayed Effective Date for Certain Internal Claims Review.* Enforcement with regard to requirements for making decisions within 24 hours for urgent claims, giving notice in a foreign language and including additional required content in the claims is delayed until the plan year beginning on or after July 1, 2011.

State External Review. The interim regulations provide that insured plans or any non-ERISA plans shall comply with State external review process that meets the standards of the NAIC Uniform External Review Act, including:

(i) review based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit;

(ii) written notice to claimants of their rights in connection with the external review;

(iii) exhaustion of internal claims and appeals process must be unnecessary where the issuer or the plan has waived the requirement, or where there has been a failure to comply with any of the requirements for the internal appeal process;

(iv) the issuer or plan against which a request for external review is filed must pay the cost of the independent review organization ("IRO") for conducting the external review; except that the State external review process may require a nominal filing fee from the claimant requesting an external review of up to $25 (to be waived on undue financial hardship);

(v) there may not be restriction on the minimum dollar amount of a claim for it to be eligible for external review;

(vi) four months to appeal must be allowed and a response is required within 45 days;

(vii) independent review organizations will be assigned on a random basis or another method of assignment that assures the independence and impartiality (such as rotational assignment);

(viii) a list will be maintained of approved IROs qualified to conduct the external review based on the nature of the health care service involved;

(ix) only IROs that are accredited by a nationally recognized private accrediting organization will be allowed;

(x) any approved IRO must have no conflicts that will influence its independence;

(xi) the claimant must have at least five business days to submit to the IRO in writing additional information that the IRO must consider when conducting the external review;

(xii) the decision must be binding on the insurer (or, if applicable, the plan), as well as the claimant except to the extent the other remedies are available under State or Federal law;

(xiii) the IRO must provide written notice to the parties of its decision within 45 days after the request;

(xiv) expedited external review is required if the adverse benefit determination concerns an admission, availability of care, or health care service for which claimant is receiving emergency services, but has not been discharged from the facility, or involves a medical condition for which the standard external review timeframe would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function;

(xiv) issuers (or plans) must include a description of the external review process in or attached to the summary plan description, policy certificate, etc. (similar to what is set forth in section 17 of the NAIC Uniform External Review Act);

(xv) the IRO must maintain written records and make them available upon request; and

(xvi) procedures for external review of adverse benefit determinations involving experimental investigational treatment (similar to what is set forth in section 10 of the NAIC Uniform External Review Act).

With regard to self-insured ERISA plans, the Federal external review process will be similar to State procedures with specific guidance to be issued (as described below).[9]

Transition Relief for Plan Years Beginning Before July 1, 2011. A transition period has been granted, pursuant to which any State review laws in effect on or before September 23, 2010 will be deemed to suffice until the plan year beginning on or after July 1, 2011.[10]

Model Notices of Initial Determination, Final Determination and External Review. The following model notices of determination were issued Aug 26, 2010: (i) notice of initial adverse benefit determination at www.dol.gov/ebsa/IABDModelNotice2.doc, (ii) notice of final internal adverse benefit determination at www.dol.gov/ebsa/IABDModelNotice1.doc, and (iii) notice of final external review decision at www.dol.gov/ebsa/IABDModelNotice3.doc.[11]

5. DOL Guidance on Federal External Review Process for Self-Insured Plans

DOL Technical Release 2010-01 (Aug. 23, 2010) [12] gives temporary guidance on the Federal external review process, which would applies to self-insured plans (as well as other plans where there is no compliant State review process), pending further guidance.[13]

- *Meeting State External Process if State Extends Program to Self-Insured Plans*. As an alternative to meeting the Federal review process, if a State chooses to expand access to their State external review

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[9] See DOL Technical Release 2010-01 (Aug. 23, 2010)

[10] Treas. Reg. § 54.9815–2719T(c)(3); DOL Reg. § 2590.715–2719(c)(3); 45 CFR § 147.136(c)(3).

DOL Technical Release 2010-02 (September 20, 2010) www.dol.gov/ebsa/newsroom/tr10-02.html provides that the government will not take adverse action against plan or insurers until July 1, 2011 where there is good faith effort to implement the procedures.

[11] See www.dol.gov/ebsa/healthreform. See also announcement of model notices at 75 Fed Reg. 52597 (Aug 26, 2010). www.gpo.gov/fdsys/pkg/FR-2010-08-26/pdf/2010-21206.pdf

[12] http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf

[13] See also notice in Federal Register about technical release at 75 Fed Reg. 52597 (Aug 26, 2010). www.gpo.gov/fdsys/pkg/FR-2010-08-26/pdf/2010-21206.pdf

process to self-insured plans, the Technical Release allows such plans to elect to meet the State external review procedures instead of Federal procedures.

Standard Federal External Review Pending Final Regulations. Procedures for standard Federal external review for self-insured plans (pending final regulations) are set forth in Technical Release 2010-1 as follows:

(i) Participant can request external review within four months after receipt of notice of adverse benefit determination or final internal adverse benefit determination.

(ii) Within five business days after receipt of external review request, the plan must complete a preliminary review as to whether: the claimant was covered under the plan, the adverse benefit determination relates to failure to meet eligibility requirements, the claimant has exhausted the plan's internal appeal process, and the claimant has provided all the information and forms required to process an external review. This must be communicated to the claimant by the next business day after the five days.

(iii) The plan must assign an independent review organization that is accredited by the Utilization Review Accreditation Commission or by a similar accrediting organization to conduct the external review. The plan must rotate between three or more IROs to avoid bias.

(iv) The IRO must use legal experts where appropriate and must notify the claimant of acceptance for review. The plan must within five business days furnish any documents or information needed to the IRO.

(v) The IRO must review the case de novo, and is not bound by conclusions of the internal review. The IRO may consider the claimant's medical records, the doctor's recommendation, the terms of the plan, appropriate practice guidelines and clinical review criteria.

(vi) The written decision of the IRO must be provided within 45 days, and such decision will include information sufficient to identify the claim (including the reason for the request, the date of service and the health care provider, the claim amount, the diagnosis code and its meaning and the reason for the previous denial), the date of receipt and decision, the evidence or documentation considered, the reason(s) for the decision (including the rationale and any evidence based standards relied on) and a statement that the determination is binding except to the extent that other remedies are available by State or Federal law and that judicial review may be available.

(vii) Records must be maintained by the IRO for six years and are available for examination by either party or government agency.

(viii) Immediately upon a decision contrary to the plan, the plan must immediately provide coverage or payment.

- *Expedited External Review*. The external review process must be expedited when the standard review deadlines would seriously jeopardize the participant's life, health or ability to regain maximum function.

6. Interim Guidance on Federal External Review Process

The Department of Health and Human Services in technical guidance [14] provides that for the plan year beginning on or after July 1, 2011, States with external review procedure that are not compliant will be subject to Federal external review procedures.

[14] HHS Technical Guidance For Interim Procedures for Federal External Review (Sept. 1, 2010) www.hhs.gov/ociio/regulations/consumerappeals/interim_appeals_guidance.pdf

In States with external review laws in effect on March 23, 2010, for plan years beginning prior to July 1, 2011, an insurer is deemed to comply if it follows that State's external review process to the extent applicable during this transition period. In States that have passed external review laws between March 23, 2010 and September 23, 2010, the process provided for under those laws will apply in that State. In States that have not passed an external review law that is in effect on September 23, 2010, a health insurance issuer must follow the interim external review process that is set forth in this technical guidance. This process will be administered by the Office of Personnel Management.[15]

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[15] HHS Technical Guidance For Interim Procedures for Federal External Review (Sept. 1, 2010) www.hhs.gov/ociio/regulations/consumerappeals/interim_appeals_guidance.pdf