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New Health Care Claims and Appeal Rules Will Include a Tax Bite

By Russell Chapman

The Internal Revenue Service (IRS), and the Departments of Labor (DOL) and Health and Human Services (HHS) have issued interim final regulations imposing new requirements on internal appeals of adverse claims decisions under group health plans (both self-insured and insured) and requiring an independent external appeal process for denied group health plan claims under the Patient Protection and Affordable Care Act of 2010, as Amended (the "Act").

The new requirements will be effective as of the first day of the first plan year beginning on and after September 23, 2010. Grandfathered plans are not subject to these new requirements. As a result, plans, insurance issuers, sponsors, and administrators who do not wish to invest the time, effort and expense of complying with the new rules, have an even greater incentive to avoid losing "grandfathered" status.

What Is Important About the New Internal and External Review Requirements?

The Act's new provisions add a substantive requirement that did not exist for group health plans before. Prior to the Act, the Employee Retirement Income Security Act (ERISA) simply included a general requirement that a plan provide a "reasonable opportunity" for a claimant to obtain a "full and fair review" of any denied claims by the named fiduciary.¹ However, there were no specific penalties provided for failure of an ERISA-covered plan to provide such a review procedure.

Under common law developed by the courts, Section 503 of ERISA implied a duty on the part of a claimant to a benefit under an ERISA plan to exhaust the plan's administrative remedies prior to filing a lawsuit. In order to assure that the administrative remedies under a plan, and particularly a group health plan, were fair, the DOL promulgated extensive regulations, which were amended and expanded in 2001, to provide detailed requirements for the administrative claims and appeal

procedures under group health plans.² These highly complex regulations (the “Section 503 Regulations”) set forth an extremely detailed set of procedures for plan administrators to follow. While the inclusion of a compliant claim and appeal procedure was a substantive requirement of ERISA, the only likely consequence of a failure to either include or follow these regulations generally was that the claimant would be relieved of the obligation to exhaust the plan’s administrative remedies and could proceed directly to court with his or her claim. A substantial body of federal common law arose mitigating this “exhaustion” requirement, including a doctrine that the procedural requirements of the regulations would be deemed satisfied, and the exhaustion requirement would apply, if the plan administrator “substantially complied” with the regulations.³

In contrast to current rules, failure to comply with the Section 503 Regulations as modified by the new internal claims and appeals and external review processes requirements may subject a health plan sponsor or health insurance issuer to a \$100 per day per violation excise tax imposed under the Internal Revenue Code, in addition to giving the claimant a green light to file suit.

The New Rules in General

The regulations:

1. provide enhanced requirements for “internal claims and appeal processes;”
2. require the application of external review processes under either state or federal law;
3. require that claim and appeal notices be provided in a “culturally and linguistically appropriate manner;” and
4. authorize the Secretary of Labor to deem certain external review processes in existence on March 23, 2010 (the date of enactment of the Act) as in compliance with the requirement to provide state or federal law external review processes.

Internal Appeal Procedures

The new regulations include six substantive and internal procedural requirements that will be available at the plan level through the plan administrator or insurer. The internal appeals procedures apply irrespective of whether the plan is self-insured or fully insured.

First, the regulations expand the definition of adverse benefit determination to include a rescission of coverage, except for failure to timely pay the covered person’s share of cost of coverage, or where the individual has not met the basic eligibility requirements of the plan. Currently, the term “adverse benefit determination” is all-encompassing, and includes any situation where a plan pays less than the amount submitted for payment.

Second, the regulations modify the Section 503 Regulations (without amending those regulations themselves) by requiring the administrator to notify the claimant of benefits determinations involving an urgent care claim as soon as possible, but not later than 24 hours after receipt of the claim (currently 72 hours under the Section 503 Regulations, which will continue to apply for “grandfathered” plans).

Third, if, during the course of the review, the administrator considers, relies on, or generates new or additional evidence, the new evidence must be provided to the claimant as soon as possible and in sufficient time to respond. Further, the written benefit determination or appeal must provide the claimant, at no cost, with the rationale for the decision, described in the new rules on explanations of benefits as a “discussion of the decision.”

Fourth, a ban is now imposed on conflicts of interest on the part of decisionmakers. The regulations prohibit entities that make group health benefit plan decisions from basing hiring, compensation, termination, promotion, bonuses, or other employment decisions on the likelihood that the individual will deny benefits. Further, the regulations require plans to hire medical experts based solely on their professional expertise and not on their reputation for supporting denial of contested claims. These new

rules may require plan sponsors, third-party administrators, and group health insurance issuers, to make adjustments to their employment policies, job descriptions, and third-party services agreements.

Fifth, the regulations add a significant level of detail to the standard explanation of benefits (EOB). Required elements in an EOB denying a claim now include the date of service, provider, amount, diagnosis code, treatment code, reasons for the denial including the denial code, and corresponding meanings of all codes, standards for medical necessity used, and a “discussion of the decision.” Unfortunately for employers, insurers and third-party administrators, the “discussion of the decision” is not otherwise defined.⁴

Further, the EOB must disclose the availability and contact information of any health insurance consumer assistance office or ombudsman under the Public Health Services Act.

Finally, if the plan fails to strictly adhere to the new regulations, the claimant will be deemed to have exhausted all administrative remedies, and thus may proceed directly to court with his or her claim, even if the plan asserts that it substantially complied with the requirements, or that any error was only *de minimis*.

The plan must provide continued coverage pending the outcome of an internal appeal and must continue to comply with Section 503 Regulations. Claimants with urgent care claims or who are undergoing an ongoing course of treatment may be permitted to proceed with the next expedited external review claim concurrently with the internal appeal.

External Review Requirements

The new rules require plans to provide procedures for an external review by an Independent Review Organization (“IRO”). The regulations do not set forth these external review procedures in detail, and those rules must await further regulatory pronouncements. In general, the anticipated rules are expected to conform to the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (the “Model Act”).

Insured Group Health Plans

Generally, if at the time the regulations become effective, the plan is a fully insured plan or not subject to ERISA preemption, and is subject to a state law external review requirement that conforms to the provisions of the Model Act,⁵ the plan will be deemed to have complied with the external review processes requirement. Further, if the issuer providing benefits under a plan complies with applicable state law external review requirements, which are at least as stringent as the Model Act, the plan itself will be deemed to have complied with the requirements of the regulations.

Generally, fully insured group health plans, or plans not subject to ERISA preemption, that are subject to a state law required external review processes will be deemed to comply with the federal external review processes requirement for plan years beginning before July 1, 2011. During the intervening time, the Secretary of HHS will determine whether state law required external review processes meet the federal standard, by comparing the state law required processes to a list of minimum consumer protections, generally using the Model Act as a guide. These minimum consumer protections will include the following:

- External reviews must be provided by an Independent Review Organization (“IRO”) which is accredited and approved by the appropriate agency or organization, is free of conflicts of interest, and is assigned on a random or rotational basis from a list of approved IROs.
- IRO review must be provided for adverse benefit determinations that are based on medical necessity, appropriateness, setting, level of care, or effectiveness.
- If the state law requires exhaustion of the internal appeal process before proceeding to IRO review, such exhaustion will not be required if it has been waived by the carrier, or in the case of a request for external review concurrently with an ongoing expedited internal review.

- The issuer must pay the cost of the external review, and claimants may not be charged more than \$25 per IRO review, nor more than \$75 for more than three IRO reviews in any one plan year.
- No minimum dollar amount may be imposed for external review of a claim, thus making external review a requirement even for nominal claim amounts.
- Claimants must be allowed at least four months to file a request for IRO review after the adverse benefit determination or final decision on the internal appeal.
- IRO review decisions must be binding on both the issuer and the claimant.
- The IRO must provide a decision within 45 days in the case of standard external review, and within 72 hours in the case of expedited external review.
- The plan must provide a description of the external review processes in summary plan descriptions, insurance policies, certificates of coverage, membership booklets, outlines of coverage or other evidence of coverage provided to participants, and maintain written records as required in the Model Act.

Self-Insured Group Health Plans

The regulations do not provide detailed federal external review processes requirements that would apply to self-insured plans or other plans and issuers that are not subject to a state law external review requirement. Rather, they indicate that these detailed requirements will be provided in future regulatory pronouncements. In general, the federal external review processes requirements will include requirements for: timeframes, rules for urgent care expedited review, time deadlines for providing decisions on external review, rules for accreditation of IROs, and other requirements that appear to be similar to those set forth under the state law external review procedures, and generally will likely follow the Model Act requirements.

“Culturally and Linguistically Appropriate” Notices

This fearsome-sounding requirement in fact adds little to existing DOL requirements that plans with participants who are literate in a non-English language must provide notices upon request in the non-English language if certain thresholds are met. These are: for plans with fewer than 100 participants, if more than 25% are literate in the non-English language, or for plans with 100 or more participants, if more than the lesser of 10% or 500 are literate in the non-English language.

Effective Date

The new requirements will be effective for non-grandfathered plans as of the first day of the first plan year beginning on and after September 23, 2010.

What You Need to Do Now

- Carefully determine the grandfather status of your plan and determine if such status will be maintained. If so, a plan sponsor must be careful with respect to the extent of changes that may be made to the plan.
- Make appropriate changes to employment policies and job descriptions to assure they are free from conflicts of interest.
- Third-party administrator service agreements must be reviewed and revised to assure they are free from conflicts of interest.
- Review plan claim and appeal procedures to determine compliance with current rules.
- Prepare for external appeal procedures compliance for non-grandfathered plans.

- Revise, amend or draft group health plan documents to comply with the new regulations. Documents such as summary plan descriptions, written plan documents, enrollment materials, benefit summaries and all claim related notices should be carefully updated.

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¹ ERISA §503(2), 29 U.S.C.A. §1133(2).

² 29 CFR § 2560.503-1.

³ Other judicially-developed doctrines had the effect of relieving the claimant of the explanation requirement, such the "futility" exception.

⁴ The dictionary definition of the term *discussion* suggests that this term means a "detailed consideration or examination of a topic." Therefore, a summary or conclusory explanation of the decision consisting of one or two sentences will no longer suffice for this purpose. For example, the commonly used claim denial language, "The claim is denied because the administrator has determined that the charges for the services exceed an amount that meets the Plan's standard for Usual and Customary Charges for the services in the relevant medical market" will clearly not meet this expanded standard.

⁵ At the present time, 44 states have enacted the Model Act.