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Internal and External Claims Review Guidance for Non-Grandfathered Health Plans Released

The agencies responsible for enforcing the health care reform law have released interim final regulations detailing the internal claims and appeals processes and external review processes applicable to non-grandfathered health plans.

Background

Under the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, group health plans in existence on March 23, 2010 are not required to comply with certain health care reform mandates as long as they continue to maintain "grandfathered" status. New plans, and plans that fail to maintain grandfathered status, are subject to a more expansive set of requirements than grandfathered plans.

Section 2719 of the Public Health Service Act (PHSA), as added by the health care reform law, requires plans that are not grandfathered to implement an internal appeals process that satisfies both the requirements of the ERISA claims regulations as well as additional standards established by the Secretary of Labor. It similarly requires these plans to comply with external review processes that meet certain requirements.

The Departments of Labor (DOL), Health and Human Services (HHS) and Treasury have released interim final regulations that provide additional information about the internal claims and appeals and external review rules applicable to non-grandfathered plans.

Interim Final Regulations

Internal Claims and Appeals Process

As noted above, non-grandfathered plans must have internal claims and appeals procedures that satisfy the requirements of the ERISA claims regulations. (See our December 20, 2000 and July 9, 2001 *For Your Information* publications.) The preamble to the interim final regulations notes that this requirement applies to non-grandfathered plans not subject to ERISA, such as governmental plans and church plans, which may not have claims procedures that comply with ERISA. In addition, the internal appeals procedures for all non-grandfathered plans, regardless of ERISA status, must also satisfy the following additional requirements.

Expanded Definition of "Adverse Benefit Determination." Under the ERISA claims regulations, an "adverse benefit determination" includes a denial, reduction, or termination of, or a failure to provide or make payment for, a benefit. The interim final regulations expand this definition to include a rescission of coverage as defined under the new law. (See our July 2, 2010 *For Your Information*.)

Reduced Timeframe for Urgent Care Determinations. The ERISA claims regulations require a plan to notify a claimant of an urgent care determination (whether adverse or not) as soon as possible, but no more than 72 hours after receiving the claim. The interim final regulations reduce this response time to no more than 24 hours after receipt of the claim.

Additional Information to Claimant. Under the ERISA claims regulations, claimants appealing an adverse benefit determination may request access to, and copies of, documentation relevant to the claim, which must be provided free of charge. The interim final regulations provide that if a plan considers, relies on or generates any new evidence during the appeal process, or bases its determination on appeal on a new rationale, it must furnish the new evidence or rationale to the claimant as soon as possible and free of charge. This documentation must be provided sufficiently in advance of the final determination so that the claimant has a reasonable opportunity to respond before the final determination is made.

> ***BUCK COMMENT.*** *Unlike the ERISA claims regulations, which require that the documentation be furnished only upon request, it appears that the interim final regulations require that documentation be provided automatically whenever the plan is considering new evidence or may base its decision on appeal on a new rationale.*

Avoidance of Conflicts of Interest. The ERISA claims regulations require a plan to ensure that claims and appeals are adjudicated by individuals who are independent and impartial. The new regulations specify that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to a claims adjudicator or medical expert cannot be based upon the likelihood such individual will deny a claim.

Language Requirements for Notices. The interim final regulations require group health plans to provide notices to claimants in a non-English language upon request if the number of plan participants who are literate only in that language meets certain thresholds. These thresholds differ based on the number of participants. For plans with fewer than 100 participants, non-English notices must be provided upon request if at least 25 percent of all plan participants are literate only in the same non-English language. For plans with 100 or more participants, non-English notices must be provided upon request if the lesser of 500 participants or 10 percent of all plan participants are literate only in the same non-English language. Once the threshold is met –

- English versions of all notices must contain a prominent statement in the non-English language offering the notice in the non-English language.
- A claimant who has requested a non-English notice must receive all subsequent notices in that language.

- Any customer assistance process, such as a hotline, offered for filing claims and appeals must also be provided in the non-English language.

BUCK COMMENT. *These requirements are based on the rules under ERISA governing the issuance of summary plan descriptions in non-English languages. It is important to keep in mind that the issue is whether a participant is literate only in the non-English language (i.e., can read only in that language) – the ability to speak English is not relevant.*

Content of Notices. The interim final regulations provide that in addition to the information required by the ERISA claims regulations, a notice of an adverse benefit determination must include the following –

- date of service, provider, and claim amount (if applicable)
- diagnosis code, treatment code and denial code (and their meanings)
- a description of any standard (e.g., medical necessity) used in denying the claim, and in the case of a final internal adverse determination, this description must include a discussion of the decision
- a description of available internal appeals and external review processes (including how to initiate an appeal)
- a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist with claims, appeals and external reviews.

The agencies are to issue model notices for this purpose.

Continued Coverage Pending Appeal Outcome. The interim final regulations require a plan to continue coverage during the appeal process, pending the outcome of the review. The regulations state that this requirement is intended to be consistent with the current ERISA regulations for claims involving concurrent care – i.e., where a plan has previously approved an ongoing course of treatment for a specified period of time or number of treatments, it cannot reduce the period/number without first providing the claimant advance notice and an opportunity to appeal.

Strict Adherence Standard

The regulations provide that if a non-grandfathered plan does not strictly comply with the claims procedure requirements, a claimant will be deemed to have exhausted the internal claims and appeals process and may immediately initiate an external review or seek relief in court. This strict adherence standard applies regardless of whether a plan has substantially complied with the rules or whether an error was de minimis. If the claimant seeks relief in court, the determination will be deemed a denial and will not be given deference by the court.

BUCK COMMENT. *This rule could have a significant effect on claims costs as courts may be more inclined to overturn adverse claims decisions when they review them without giving any deference to plan administrators' decisions.*

External Review Processes

Section 2719 of the PHSA provides for two types of external review processes – state and federal – that will be applied to non-grandfathered plans. Health insurance issuers and self-funded plans, such as governmental plans, church plans and multiemployer welfare arrangements (MEWAs) that may be subject to state insurance laws, generally will be subject to state external review processes. The regulations note that if a health insurance issuer is required to comply with the applicable state external review process, then to the extent a group health plan's benefits are provided through that issuer, the plan itself will not be required to comply with either the state or the federal external review process. Self-funded ERISA plans must have external review processes that comply with federal requirements. Insurance issuers, insured plans and self-funded non-ERISA plans will also be required to comply with federal requirements if a state law does not provide for an external review process or if the state process fails to meet certain minimum standards.

State External Review Process

The regulations provide that an issuer or plan is required to comply with the state external review process if the process is binding and meets minimum consumer protections under the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act (NAIC Model Act). At a minimum, the external review process must –

- provide for external review of adverse benefit determinations that are based on the issuer's or plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit
- require issuers or plans to provide written notice of the claimant's rights with respect to the external review
- make exhaustion of internal claims and appeals process unnecessary where the issuer or plan has waived this requirement, the claimant is deemed to have exhausted the internal process, or the claimant applied for an expedited external review at the same time as applying for an expedited internal appeal
- provide that the issuer or plan pay the cost of the independent review organization (IRO) conducting the external review (although a nominal filing fee of $25 per claim (not to exceed $75 per year) may be imposed on the claimant unless there would be undue financial hardship)
- not include a minimum dollar threshold for a claim to be eligible for review (e.g., $500 minimum claim)
- give claimants at least four months after an adverse benefit determination to request an external review

- require plans or issuers to include a description of the external review process in or attached to the SPD or other evidence of coverage provided to participants (similar to what is set out in the NAIC Model Act)
- follow procedures for review of determinations involving experimental/investigational treatments that are substantially similar to those in the NAIC Model Act
- provide for expedited external review for adverse benefit determinations that concern an admission, availability of care, continued stay, or health care service for which the claimant received emergency services and the claimant has not been released, or involve other medical conditions where the standard review time frame would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, and require the IRO to make a decision within 72 hours of the receipt of the request
- require that IROs be approved by a nationally recognized private accrediting organization and that the state process assures there are no conflicts of interest affecting independence
- allow claimants to submit additional information to IROs and require notification of the right to do so, and impose other requirements on the IRO (e.g., provide written notice of the decision to uphold or reverse a determination, maintain records consistent with the NAIC Model Act)
- provide that determinations are binding on both parties, except to the extent there are other state or federal remedies.

The agencies are asking for comments on whether other elements of the NAIC Model Act should apply.

Transition Period. Existing state external review processes will be treated as meeting the minimum standards during a transition period for plan years beginning before July 1, 2011.

Final internal determinations made during a plan year beginning before July 1, 2011 (January 1, 2011 for calendar year plans). For these determinations, health insurance issuers subject to an existing state external review process must comply with this process and not the federal external review process. If a state does not have an external review process, self-funded non-ERISA plans and MEWAs would be required to comply with the federal external review process for that claim. A self-funded ERISA plan would also have to comply with the federal external review process.

Final internal determinations made during a plan year beginning on or after July 1, 2011 (January 1, 2012 for calendar year plans). For these determinations, self-funded non-ERISA plans and MEWAs would have to comply with an applicable state external review process if HHS determines that the process meets the standards. If not, then non-ERISA plans and MEWAs must comply with the federal external review process.

Federal External Review Process

Although the regulations do not detail the federal review process requirements, they indicate that the process will be similar to that in the NAIC Model Act and will meet standards issued by HHS. The agencies will address in "subregulatory guidance" how non-grandfathered self-funded group health plans may comply or be brought into compliance with the federal external review process requirements.

It should be noted that the regulations specify that determinations based on a participant's eligibility to participate in a plan are not eligible for this federal external review.

As noted earlier, if the applicable state external review process does not meet the requirements described above, or if there is no state external review process, non-grandfathered plans must implement a process that satisfies the requirements applicable to the federal external review process.

Effective Date

Non-grandfathered plans will need to satisfy the internal and external review requirements beginning with the first day of the first plan year beginning on or after September 23, 2010. Thus, non-grandfathered calendar year plans must comply beginning January 1, 2011.

Conclusion

Sponsors of non-grandfathered health plans and plan sponsors considering changes that would cause the loss of grandfathered status will need to carefully review these regulations and ensure that they are prepared to timely implement the new procedures. Buck's consultants would be pleased to discuss these latest regulations and how they may affect your health plans.