

# ALERT: HEALTH CARE REFORM BILL

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## RULES ON HANDLING CLAIMS FOR MEDICAL BENEFITS

The interim final regulations implementing the health care reform law's requirements for health benefits claims are more "interim" than "final." Although the regulations are effective for plan years starting on or after September 23, 2010 (January 1, 2011 for calendar year plans), they probably will be revised significantly before becoming final, and plans that comply at the initial effective date can look forward to further overhauling their claim procedures in future years. Plans that can retain grandfathered status may save themselves one or more revisions of their claim procedures because grandfathered plans are exempt from the new requirements. Employer-sponsored plans that must comply will need to work with insurers, TPAs and other third parties that process claims to determine what is needed in order to comply.

### BACKGROUND

The health care reform law requires *non-grandfathered* health plans – including non-grandfathered employer-sponsored group health plans – to have:

- Internal claim and appeals procedures that meet the current ERISA standards for health benefit claims as well as some additional requirements
- External review processes for denied claims that meet certain standards

The three federal agencies responsible for implementing these claim handling requirements have published interim final regulations and supplemented those with several pieces of "sub-regulatory" guidance, including agency enforcement policies that are intended to delay some of the claim requirements. Even with the enforcement policies and several helpful transition rules, complying with the claim handling requirements is a daunting task.

### MEANING OF INTERNAL AND EXTERNAL

"Internal" claim procedures are those that traditionally are carried out by a plan's insurer or third-party administrator and include submission of claims, initial claim decisions and decisions when denied claims are appealed. Even though these functions are not usually performed by the employer, we refer to them as internal because the decision makers are acting on behalf of the plan. Like internal procedures, "external" review may be carried out by a third party hired by the employer (or the insurer or TPA), but the third party must meet certain criteria and the review must comply with rules intended to ensure the decision maker's independence and neutrality.

## THE BIG PICTURE

**INTERNAL CLAIMS AND APPEALS REQUIREMENTS.** Most employers' health plans are subject to ERISA's internal claims and appeals requirements and comply by delegating claim processing to an insurer, TPA or other third party. Plans that are exempt from ERISA (e.g., church and governmental plans) are not subject to these rules. Insurers providing coverage under ERISA plans are only responsible for following the ERISA rules if and to the extent that they enter into contracts requiring them to do so.

The new claim requirements don't directly amend the existing ERISA rules. They incorporate the ERISA standards for internal claims and appeals into a new set of rules, add some new requirements and make the resulting rules applicable to church, governmental and all other group health plans and health insurers (subject to exemptions for grandfathered and certain other plans). The interim final regulations explain several new internal claims and appeals requirements, and subsequent sub-regulatory guidance delays some of those requirements, as explained below. Employers whose plans must comply with the new requirements need to verify that the plans' claim payers will revise their procedures accordingly. Such employers may also enlist their claim payers' assistance in communicating the changes to participants.

**EXTERNAL REVIEW REQUIREMENTS.** Before enactment of the health care reform law, there generally were no federal requirements for employee benefits plans to have external review procedures. Many insured employer-sponsored plans had such procedures, however, because many states' insurance laws required the insurers providing coverage under the employer-sponsored plans to provide external reviews. Subject to exemptions for grandfathered and certain

other plans, the new claim rules require church, governmental and all other group health plans and health insurers to provide for external review of denied claims. The interim final regulations explain that most insured and a few self-insured plans may satisfy the federal external review requirements by complying with state external review requirements. For most self-insured plans, however, the interim final regulations only sketch an overall picture of the requirements. Later sub-regulatory guidance provides standards for self-insured plans' external review processes, as described below. To the extent that a group health plan's benefits are provided by an insurance policy subject to state external review requirements that satisfy the regulations' requirements as explained below, the insurer providing the policy is exclusively responsible for compliance with the external review requirements. Employers that sponsor such insured plans need not take any steps to ensure compliance with the external review requirements. Employers whose plans must comply with the new external review requirements should determine whether the plans' claim payers will implement processes that meet the requirements and will assist with communicating those processes to participants.

## PLANS SUBJECT TO THE NEW RULES

Like several other provisions that become effective for employer plan years starting on or after September 23, 2010, the claim handling rules generally apply to the group health plans that must comply with the HIPAA portability rules. This means that rules very similar to the existing ERISA claims and appeals requirements will apply to church and governmental plans for the first time. At the same time, however, ERISA's claims and appeals requirements continue to apply to all plans that are subject to ERISA, including some (such as stand-alone dental and vision plans) that are exempt from the new claim handling requirements. This means that the health benefits maintained by a single employer will have different claim procedures, and participants will have different mechanisms available for appealing denials, depending on which plan provides a particular benefit. These variations in the applicable requirements may create considerable confusion for employers and participants.

The chart below summarizes which types of benefits are subject to previously existing ERISA rules and which types are subject to the additional claim handling requirements under the health care reform law (including external review requirements).

Type of Employer-Sponsored Health Plan	ERISA Claim Requirements Apply?	Additional HCR Claim Requirements Apply?
Major Medical (including HMO, PPO, HDHP, etc.)	Yes (including requirements relating to urgent pre-service claims <sup>1</sup> ) except that a governmental or non-electing church plan is exempt if it is also grandfathered <sup>2</sup> or retiree-only <sup>3</sup>	Yes, unless grandfathered <sup>2</sup> or retiree-only <sup>3</sup>
HRA	Same as Major Medical	Same as Major Medical
Mini Med (also called limited health plans)	Same as Major Medical	Same as Major Medical
EAP	Same as Major Medical	Same as Major Medical
Executive Medical Expense Reimbursement Program	Same as Major Medical; some may be exempt supplemental coverage (see below)	Same as Major Medical; some may be exempt supplemental coverage (see below)
Qualified Health FSA <sup>4</sup>	Yes, unless a governmental or non-electing church plan	No
Stand-alone Dental or Vision <sup>5</sup>	Same as Qualified Health FSA	No
Hospital or Other Fixed Indemnity <sup>6</sup>	Same as Qualified Health FSA	No
Supplemental Coverage <sup>7</sup>	Same as Qualified Health FSA	No
Specified Disease <sup>8</sup>	Same as Qualified Health FSA	No

<sup>1</sup> While the DOL rules regarding pre-service claims technically apply to any plan that provides health benefits, major medical plans generally are the only health plans that reduce benefits for failure to obtain authorization before medical services are provided.

<sup>2</sup> For information on determining whether a benefits package is grandfathered, see Willis Human Capital Practice *Alert* Vol. 3, No. 12 **“Regulations on Grandfathered Plans.”**

<sup>3</sup> Retiree-only refers to coverage provided through a separate ERISA plan, all participants of which are retirees.

<sup>4</sup> A health FSA under which the maximum benefit available from the FSA does not exceed twice the employee’s pre-tax contribution or, if greater, \$500 plus the employee’s pre-tax contribution and which is offered in addition to major medical coverage that has an annual open enrollment. While Qualified Health FSAs typically are offered under cafeteria plans, a health reimbursement arrangement (HRA) (under which an employer makes a specified dollar amount available to reimburse health care expenses, with no employee contributions) may be a Qualified Health FSA if it provides a maximum annual benefit of \$500 or less and is otherwise a Qualified Health FSA.

<sup>5</sup> Coverage providing dental or vision benefits if the coverage is: (1) provided through a policy, certificate or contract of insurance that is separate from a major medical plan; or (2) optional, with employees who elect coverage being required to pay an additional amount.

<sup>6</sup> Coverage provided under a separate policy, certificate or contract of insurance that does not coordinate benefits with any other plan of the employer and pays a specified dollar amount for each day (or other period) that a covered individual is hospitalized or ill, regardless of whether or how much the individual incurs for care while hospitalized or ill and regardless of whether or how much any other plan of the employer pays.

<sup>7</sup> Coverage provided under a policy, certificate or contract of insurance that is a Medicare or Tricare supplement or “similar” supplemental coverage that is specifically designed to fill gaps in the primary coverage, costs no more than 15% of the cost for the primary coverage and does not vary eligibility, premiums or benefits based on any health factor of an employee or dependent.

<sup>8</sup> Coverage provided under a separate policy, certificate or contract of insurance that covers a specified disease or illness, such as cancer or heart disease, including reimbursement of expenses for treatment, and does not coordinate benefits with any other plan of the employer.

## ADDITIONS TO ERISA'S INTERNAL CLAIMS AND APPEALS REQUIREMENTS

As noted earlier, the new internal claims and appeals requirements are essentially those required currently for health benefits governed by ERISA plus some additional requirements and, subject to some exemptions, the requirements are extended to all group health plans (not just ERISA plans) for plan years starting on or after September 23, 2010. The new requirements also apply to carriers providing insured health benefits. For employers, this means that an insurer issuing a health insurance policy to the employer will be at least as responsible for compliance with internal claim requirements as the employer.

For non-ERISA plans, complying with the new internal claims and appeals rules may require extensive revisions to existing claim procedures. For ERISA plans, compliance requires adding some procedures to existing plan provisions. Even for ERISA plans, however, the new requirements are not easily met, and the agencies have delayed enforcement of several of the new provisions for plans working in good faith to implement them. The delays are noted in the listing of requirements below.

Comment: While the agencies' sub-regulatory efforts to allow additional time for compliance are welcome, employers and other plan sponsors should keep in mind that the agencies' decision to delay enforcement is not binding on anyone else who has authority to enforce the requirements. Because these provisions are part of ERISA and the Public Health Service Act, individual participants and beneficiaries under a plan have a right to enforce the requirements of those laws in a court case against the plan.

### NEW REQUIREMENTS FOR INTERNAL CLAIMS AND APPEALS PROCEDURES.

The interim final regulations specify seven changes to the procedures currently governing ERISA plans that provide health benefits.

- The “adverse benefit determinations” that trigger a plan’s appeals process are broadened to include rescissions of coverage (i.e., retroactive cancellation for reasons other than failure to pay premium). In most cases, plans are not required to treat a request as a claim unless its outcome will determine or affect the amount of benefits payable, so eligibility issues generally are not subject to plans’ claim procedures unless an eligibility determination results in denial of payment. In the case of a rescission, however, a plan must treat a rescission of coverage as a denied claim, even if no benefit payments are affected by the rescission. (For additional information on the provisions restricting rescissions, see **Willis Human Capital Practice Alert Vol. 3, No. 13, “Patient’s Bill of Rights Guidance Issued.”**)
- The interim final regulations shorten the maximum time allowed to notify a claimant of the plan’s decision with respect to an urgent pre-service claim to 24 hours after receipt. (The ERISA claim rules currently allow 72 hours for this notice.) *The timing change is one of the new provisions that the agencies will not enforce before July 1, 2011 if a plan is working in good faith to implement the shorter decision deadline.* An employer will want to determine when the insurer or TPA processing claims will implement the 24-hour standard and make sure plan materials reflect that date.
- Claimants generally cannot sue for benefits until they have followed the plan’s claims and appeals procedures and a final decision under those procedures has been reached. There is an exception to this “exhaustion” requirement, however, if the plan’s claims and appeals procedures do not meet applicable standards or the plan does not follow its procedures. Current authorities use a “substantial compliance” standard to determine if a claimant is required to exhaust a plan’s claims and appeals procedures and do not allow claimants to bypass the procedures if an error is *de minimis* (i.e., insignificant). The new rules tighten this standard, allowing a claimant to sue or pursue an external review if the plan fails to “strictly adhere” to required internal claims and appeals procedures. *Enforcement of the strict adherence standard is delayed until July 1, 2011 for plans working in good faith to implement the new requirements.*
- The interim regulations specify that persons involved in claims and appeals decisions cannot be chosen, compensated or promoted based on actual claim denials or the likelihood of upholding an adverse benefit determination.

- Each notice of an adverse benefit determination must include more information than current standards require. In particular, the notice must include additional information identifying the expenses considered (such as date of service, provider name, amount of claim, diagnosis and treatment codes, etc.) and additional information regarding the claim denial (such as denial code and meaning). Model notices show how to provide the required information. **The Model Notice of Adverse Benefit Determination** is for use when the plan first decides to deny a claim and the **Model Notice of Final Internal Adverse Benefit Determination** illustrates the notice that the plan is to provide when all internal appeals have been completed and the claim denial is confirmed. *Enforcement of these disclosure standards is delayed until July 1, 2011 for plans working in good faith to comply.*
- The interim final regulations require additional and earlier disclosure of any new or additional evidence considered, relied upon or generated in connection with an appeal of an adverse benefit determination and any new or additional rationale for the decision on appeal. The plan must automatically disclose this information to the claimant (not just provide it upon request) as soon as possible and sufficiently in advance of the decision deadline to give the claimant time to respond before the deadline arrives.
- Notices provided in the course of the claims and appeals process must be provided in an alternate language if certain thresholds based on the number of people literate only in the same non-English language are met. A plan meeting the applicable threshold must include in its notices a prominent statement in the non-English language offering to provide the notice in that language. In addition, if an individual requests the notice in the alternate language, the plan must provide all subsequent notices and customer assistance to that individual in the non-English language. The thresholds for this requirement are the same as those under ERISA's rules for SPDs: 10% or more (25% or more for small plans) of a plan's participants or, if less, 500 participants, are literate only in same non-English language. *Enforcement of the alternate language requirement is delayed until July 1, 2011 for plans working in good faith to provide alternate language assistance.*

## EXTERNAL REVIEW REQUIREMENTS

Each group health plan that is subject to the new claim handling requirements must have an external review process that meets certain standards. The process must be available to claimants who have received a final adverse benefits determination through a plan's internal claims and appeals process or who request an expedited external review concurrent with an urgent internal appeal. Claimants cannot be required to use a plan's external review process before or in lieu of bringing a lawsuit, however. Claimants retain the right to go to federal court after internal claims and appeals procedures are exhausted (or deemed exhausted due to the plan's non-compliance with applicable standards).

The interim final regulations specify that a group health plan's external review processes must meet federal standards unless the regulations require the plan to use an external review process mandated by state law.

### **INSURED PLANS GENERALLY MUST USE STATE EXTERNAL REVIEW PROCESSES.**

The agencies' rules rely on state external review processes to the extent that they are applicable and meet certain standards. This reliance primarily affects plans that provide insured health benefits, but it also may affect some self-insured plans that are subject to state laws (e.g., church and governmental plans and multiple employer welfare arrangements).

The interim final regulations set minimum criteria that the state processes must meet in order to satisfy federal requirements. The criteria are based on the **Uniform Health Carrier External Review Model Act** created by the National Association of Insurance Commissioners (NAIC). If a state's external review requirements meet these standards and are binding on an insurance policy or group health plan, then the insurance policy or group health plan must comply with those state processes in order to satisfy the federal external review requirement. Moreover, to the extent that a group health plan's benefits are provided by an insurance policy that is subject to such state requirements, the insurer providing the policy is exclusively responsible for compliance with the external review requirements. The employer need not take any steps to ensure compliance.

For plan years beginning before July 1, 2011, any state external review process that applies to a policy or plan will be considered binding on the plan and will be deemed to meet the minimum criteria needed to satisfy the federal requirements. This transition rule is intended to allow states time to amend their external review laws in order to bring them into compliance with the NAIC model act criteria. For plan years starting on or after July 1, 2011, plans and policies in states whose external review requirements still do not meet these standards must comply with federal external review standards.

Of course, if no state external review law applies to a plan or policy, that plan or policy will be subject to federal external review standards starting the first plan year on or after September 23, 2010. HHS has issued interim guidance for insurers whose policies are not subject to any state external review law. While not entirely clear, it appears that group health plans providing insured benefits subject to HHS' interim guidance may rely on the insurer for compliance. HHS has advised self-insured plans in this situation – including self-insured plans that generally are subject to state laws – to comply with the interim guidance described in the following section.

### **SELF-INSURED PLANS GENERALLY MUST USE FEDERAL EXTERNAL REVIEW PROCESSES.**

The federal external review process applies to plans that are not required to comply with a state external review process (such as self-funded ERISA plans). While the interim final regulations set out several criteria for the federal external review process standards, the regulations do not actually set those external review standards. To fill this gap, the DOL issued sub-regulatory guidance providing two options for compliance with the external review requirement for plan years beginning on or after September 23, 2010 until superseded by future guidance on the federal process:

- A plan may voluntarily comply with a state's external review procedures where the state has elected to make those procedures available to self-insured plans
- A plan that does not comply with state standards must comply with the safe-harbor procedures set out in the DOL sub-regulatory guidance, which are based on the NAIC Model Act

A plan's compliance with either of these standards ensures that the federal agencies will not take enforcement action, but does not ensure that a court deciding a case brought by a participant will find that the plan has complied with the

external review requirement. Similarly, noncompliance with these standards does not necessarily result in violation of the law's external review requirements.

Unfortunately, a self-insured plan's TPA does not have any responsibility to comply with these requirements. While an employer sponsoring a self-insured plan may delegate to the plan's TPA responsibility for setting up and administering external review requirements, the employer remains responsible for compliance and any penalties for noncompliance generally will fall on the employer. Employers should consult with their TPAs, to determine what assistance they will provide in establishing and operating external review processes.

Complying with the safe-harbor procedures in the DOL's sub-regulatory guidance requires significant administrative effort.

- The plan must arrange for an independent review organization (IRO) to conduct each review according to federal standards. Those standards must be part of contract between the IRO and the plan and there can be no financial incentive for the IRO to support denial of benefits. According to the safe harbor, each plan must contract with at least three IROs that are accredited by URAC or similar organization and rotate reviews among them.
- Under the safe harbor, a claimant may obtain an external review by requesting it within four months after receiving notice of a final internal adverse benefit determination or whenever deemed exhaustion (of the internal claims appeals process) applies. Expedited external review must also be available upon request in some cases, and may even be required concurrent with consideration of an urgent internal appeal.
- A group health plan complying with the safe harbor must have a process for preliminary review of external review



requests. The plan must determine within five business days of receiving a request for review whether the claim is eligible for external review and must notify the claimant of the decision within one business day. (In the case of an expedited review, the determination and notice must be “immediate.”) If a claim is ineligible for external review, the notice must explain why and, if the request for review is incomplete, the notice must explain what information is needed. The claimant then has the remainder of the four months or, if greater, 48 hours to resubmit the request for review.

- For each request that qualifies for external review, the plan must assign the claim to one of its IROs. Within five business days or “expeditiously” in case of expedited review, the plan must provide the IRO with the information considered during internal claims and appeals process.
- If the IRO decides in favor of the claimant, the plan must “immediately” provide coverage or payment, and the IRO must provide notice of the decision. The DOL has provided a **Model Notice of Final External Review Decision**.

## **CURRENT STATE OF GUIDANCE MAKES GRANDFATHERED STATUS ATTRACTIVE**

Plans that implement the new claim handling requirements during the next several months can look forward to once again significantly revising their internal claims and appeals procedures and external review processes within the following year as interim guidance is finalized. A plan that was in existence on March 23, 2010 can avoid these repetitive revisions by retaining grandfathered status until more definitive guidance is issued. Employers that previously saw little value in keeping grandfathered status for their plans may wish to reevaluate in light of the difficulties with the new claim handling requirements. For those plans unable to maintain grandfather status, the employer should discuss compliance efforts with its TPA or insurer.

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