

ALERT: HEALTH CARE REFORM BILL

August 2011

www.willis.com

INTERNAL AND EXTERNAL REVIEW/APPEALS PROCESS UPDATED

On June 24, 2011, final guidance was released that implements the new internal claim and appeals, and external review processes under Health Care Reform. The requirements were effective for non-grandfathered health plans for plan years starting on or after September 23, 2010. The new guidance provides some relief from the initial guidance issued in July 2010.

The U.S. Departments of Health & Human Services (HHS), Department of Labor (DOL) and Treasury (IRS) amended (and twice updated) the Interim Final Rule (IFR) issued last year, which implemented the Patient Protection and Affordable Care Act (PPACA) mandate. PPACA established the right for health plan members to receive information about why a claim or coverage has been denied, a right to appeal if coverage was rescinded and a right to an independent third party to review the insurer's/administrator's decision (external review) – effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). Two subsequent releases delayed the effective date for certain requirements of the rules – some until plan years beginning on or after July 1, 2011, others until plan years beginning on or after January 1, 2012.

The new guidance from the agencies consists of:

- An amendment to the July 2010 regulations
- DOL Technical Release 2011-02 (including revised model notices) that clarifies and makes changes to the July 2010 regulations and subsequent enforcement guidance

The new guidance provides additional transition relief and eases or clarifies a number of the rules in the July 2010 regulations. Under the Amended Interim Final Rule (AIFR), plans and insurers/third-party administrators (TPAs) must continue to comply with existing DOL claim and appeals regulations. See:

<http://www.dol.gov/ebsa/newsroom/tr11-02.html>

<http://www.gpo.gov/fdsys/pkg/FR-2011-06-24/html/2011-15890.htm>

While the AIFR was effective July 22, 2011, the Agencies retained and extended some of the prior grace periods, so provisions continue to have different effective dates.

NOTE: While the agencies' decision to allow added time for compliance is welcome, employers and other plan sponsors should keep in mind that this 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.

The AIFR also extends the transition period to January 1, 2012 for states to develop their external review processes, affording them an opportunity to fully implement the 16 minimum consumer protections based on the Uniform Health Carrier External Review Model Act developed by the National Association of Insurance Commissioners (NAIC). The AIFR anticipates that a state's qualifying external review process will be used in lieu of a federal external review process.

This Alert updates and restates portions of prior Willis guidance, see Willis Human Capital Practice **Alert, Vol. 3, No. 16, "Rules for Handling Claims for Medical Benefits, Alert, Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011"**. See also Willis Human Capital Practice **Alert, Vol. 3, No. 12, "Regulations on Grandfathered Plans"**).

Last year, we described PPACA's added internal appeal and external review requirements as "draconian." Following the relief announced last month, maybe we can scale that back to "harsh." On the other hand, we can all expect more guidance in the future, so it may be too soon to celebrate. The AIFR reconfirms that these new PPACA rules do not apply to grandfathered plans. While insurers and TPAs will likely bear the brunt of the compliance burden, there may still be value in remaining in the grandfather group. For those plans that are not grandfathered or find that they unable to maintain grandfather status (remember, grandfather status is measured plan by plan, option by option), the employer should discuss compliance efforts with its TPA or insurer.

NOTE: *More guidance is already on the way.* ERISA requires that each employee benefits plan provide "adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied." The notice must set forth the specific reasons for the denial and must be written in a manner calculated to be understood by the claimant. Each plan must also afford "a reasonable opportunity" for a participant or beneficiary whose claim has been denied to obtain "full and fair review" of the denial by the "appropriate named fiduciary of the plan." On July 7, the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) released its semi-annual Regulatory Agenda and confirmed that they intend to issue new proposed regulations in December 2011 to update the current ERISA claim and appeals process.

DISCUSSION

PPACA added a considerable amount of new compliance requirements to employer plans, including new appeals processes so that **non-grandfathered** health plans must now:

- Meet current ERISA standards for internal claim and appeals procedures
- Adopt new, additional provisions for claims and appeals
- Add external review processes for certain denied claims

BACKGROUND

Most employers' health plans are already subject to ERISA's internal claim and appeals requirement – including requirements relating to urgent pre-service claims. Most insured coverage is also subject to state-based insurance requirements concerning claims and appeals. The new PPACA internal claim and appeals/external review requirements generally do not apply to life insurance, AD&D, disability benefits or stand-alone/limited-scope dental or vision benefits – excepted benefits under HIPAA portability rules – so claim procedures for those benefits would continue to be governed solely by the pre-PPACA rules.

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 and add some new requirements.

Plans that are exempt from ERISA (e.g., church and government plans) are not subject to the ERISA internal claim and appeals requirements, but they WILL be subject to the new rules under PPACA. PPACA takes those rules and extends them to health plans that must comply with the HIPAA portability rules – so they also apply to church, government and all other group health plans and health insurers (except where the plans qualify under grandfather, retiree-only or other exemptions).

ERISA does not require an external review procedure. However, many plans were subject to external review as part of state insurance law compliance. Unless exempt under PPACA, insured and self-insured health plans need to add an external review of denied claims. Most insured plans can meet this requirement by complying with state external review requirements – the insurer providing the policy is exclusively responsible for compliance. Employers that sponsor such insured plans need not take any steps to ensure compliance with the external review requirements. Other employers must determine whether the insurer/TPA has implemented processes to meet these requirements. Either way, the employer will have a major role in communicating the processes to participants.

“Internal” claim/appeal procedures are those traditionally carried out by an insurer or TPA acting on behalf of the plan – submission of claims, initial claim decisions and decisions on appeals of denied claims. “External” review must be completed by an independent and neutral third party.

WHICH PLANS MUST COMPLY?

Which rules apply to your *employer-sponsored* plans? Some rules of thumb are:

- ERISA health plans (indemnity, HMO, PPO, HDHP, HRAs [health reimbursement arrangements], mini-med/limited, and certain employee assistance plans) are subject to the ERISA claim requirements – these plans are also subject to the new PPACA requirements (unless grandfathered or retiree-only).
- Although qualified health Flexible Spending Accounts*, stand-alone dental and vision, hospital and other fixed indemnity, supplemental coverage and specified disease coverage are also subject to the ERISA claim requirements, these plans are not subject to the new PPACA requirements.

Under these PPACA changes, the 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 claim and appeals rules may require extensive revisions to existing claim procedures. For ERISA plans, compliance requires adding some procedures to existing plan provisions.

**A qualified health FSA is a FSA where the maximum benefit 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.*

INTERNAL CLAIM AND APPEALS PROCEDURES

The IFR contained seven changes, recounted below, to the prior ERISA appeals process. Changes based on the June 2011 AIFR are shaded.

1. 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). Eligibility issues generally are not subject to a plan’s 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.
2. The maximum time allowed to notify a claimant of the plan’s decision with respect to an urgent pre-service claim will continue to be 72 hours as required under pre-PPACA ERISA rules. The AIFR reverses the IFR requirement of 24 hours and specifically confirms decisions should be made “... as soon as possible ... **but not later than 72 hours after receipt of the claim.**”
3. Under the IFR, a plan must “strictly adhere” to the required internal claim and appeals provisions, else claimants can assert they have exhausted the internal process and demand an external review or pursue judicial remedies. The AIFR generally retains the “strict adherence” compliance standard, but incorporates an exception for minor compliance errors, “...the internal claims and appeals process will not be deemed exhausted based on

deminimis violations that do not cause...prejudice or harm to the claimant...(where) the violation was for good cause or due to matters beyond the control of the plan...in the context of an ongoing, good faith exchange of information between the plan and the claimant...(and is not part of a) pattern or practice...” (Deminimis means insignificant.) The AIFR also enables participants to obtain an explanation of any deminimis violation and a process to challenge the determination that the violation was deminimis.

4. The IFR requires that those involved in claims and appeals cannot be chosen, compensated or promoted based on actual claim denials or the likelihood of upholding an adverse benefit determination.

5. The IFR expanded the information that must be included in any adverse benefit determination to ensure the participant can identify the claim involved and the reason for the determination - date of service, health care provider, claim amount, and the diagnosis and treatment codes, as well as the denial code and meaning. The AIFR changes this requirement to include “...the date of service, the health care provider, the claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning...” where the requested information must be provided “as soon as practicable, upon request.”

6. The IFR provides new guidelines for plans/insurers that require added 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 rationale here is to ensure the information is provided in advance of a final determination so as to minimize situations where a plan/insurer adds a brand new reason for denial to its final decision, perhaps intending to insulate the reason for denial from review.

7. The IFR applied the ERISA Summary Plan Description (SPD) rules for non-English-speaking participants – where 10% or more of participants, or if less, 500 participants, are literate only in the same non-English language. The percentage is 25% or more for small plans. As a result, the IFR set different standards for the group and individual markets. The AIFR changes the regulation to require the plan to provide oral language services and claims and appeal assistance in applicable non-English languages. The AIFR also requires the plan to provide, upon request, a notice in any applicable non-English language and to include in English notices, instructions, in any applicable non-English language, of how to access the language services provided by the plan or issuer. The AIFR also confirms that the determination of “applicable non-English language,” is determined on a county- by-county basis, applicable where 10% or more of the residents are literate only in the same non-English

language. The AIFR confirmed that the plan/insurer need not “tag and track” individuals and provide them with future notices in the applicable, non-English language. The agencies provided a listing of each county in America that meets these requirements.

NOTE: Most of the applicable, non-English language counties have Spanish as the language and are in Texas, California and Puerto Rico. One lists Chinese, two list Tagalog and three list Navajo. The disclosure must apply based on the county in which the **claimant** is located. Since “tag and track” no longer applies, some plans/insurers will comply by simply posting the non-English language information on every notice.

The Department of Labor provided a list of applicable non-English language counties in Table 2 of the proposed regulations, starting on page 37221. They can be accessed by [clicking here](#).

The Department of Labor published a guide for consumers showing which states, as of May 23, 2011, have set up consumer assistance operations to help guide patients through the appeals and review process. Access by [clicking here](#).

EXTERNAL REVIEW REQUIREMENTS

PPACA and the IFR require each plan subject to the new claim handling requirements to include an external review process. The process must be available to claimants who have received a final adverse benefits determination through a plan’s internal claim and appeals process or who request an expedited external review concurrent with an urgent internal appeal. 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 except where an external review process is mandated by state

law. Insured plans, and self-insured plans that are subject to state laws (e.g., church, government plans and multiple employer welfare arrangements), generally must use state external review processes where the states meet the minimum criteria based on the Uniform Health Carrier External Review Model created by the National Association of Insurance Commissioners (NAIC). Where insured, the insurer is exclusively responsible for compliance.

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). The IFR did not confirm the external review standards, but DOL issued sub-regulatory guidance that provided two options for compliance:

1. 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.
2. A plan that does not comply with state standards must:
 - Allow for external reviews up to four months after receiving notice of a final internal adverse benefit, determination or whenever deemed exhaustion (of the internal claim appeals process) applies.
 - Provide for an expedited external review, upon request, even if concurrent with consideration of an urgent internal appeal.
 - Determine within five business days of receiving a request for review whether the claim is eligible for external review, "immediate" in any expedited review.
 - Notify the claimant of the decision within one business day, "immediate" in any expedited review, explaining why the claim is ineligible for external review and, where the request for review is incomplete, explain what information is needed – allowing the claimant an opportunity to resubmit the request for review until the later of 48 hours or the remainder of the four-month period.
 - Arrange for an independent review organization (IRO) to conduct each review according to federal standards. The AIFR confirmed plans must contract with at least two IROs by January 1, 2012, and at least three IROs by July 1, 2012, where those IROs are accredited by URAC or a similar organization, rotating reviews among them.

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 AIFR clarifies that the plan or insurer must, without delay, make payment on the claim pursuant to a final external review decision, regardless of whether the plan intends to seek judicial review of the external review decision.*

NOTE: This requirement to pay first and try to recover later is controversial and makes the IRO's decision all but final. Recovery costs will likely be part of any consideration about attempting a judicial appeal. Many consider this to be regulatory overreach.

The AIFR delays the effective date to provide states added time, until January 1, 2012, to meet the NAIC external review requirements. By July 31, 2011, HHS intends to issue determinations regarding each state's compliance with the external review process standards. Existing state external review processes are deemed compliant until December 31, 2011. On or after January 1, 2012, the federal external review process will apply unless HHS determines that a state law meets all the minimum standards. The Departments have also established a set of temporary standards that will apply until January 1, 2012. According to the Technical Release 2011-02, states without external review programs as of June 22nd include Alabama, Mississippi and Nebraska, while the following territories do not currently

have external review programs, American Samoa, Guam, Northern Marianas and the U.S. Virgin Islands.

The AIFR confirms that eligibility determinations were removed from the external review process requirement. That is, “...a denial, reduction, termination or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the Federal external review process...”

Subject to further guidance, until January 1, 2014, the AIFR also confirms that the federal external review process will “...apply only to: An adverse benefit determination... That involves medical judgment (including but not limited to those based on the plan’s or issuer’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational)...and a rescission of coverage.

The NAIC summary of state compliance with the external review process, updated as of June 15, 2011, can be accessed by [clicking here](#).

MODEL NOTICES

The AIFR also updated the model notices and model language for a description of the internal claim and appeals and external review procedures to be included in the SPD.

- A revised notice of **Adverse Benefit Determination**
- A revised notice of **Final Internal Adverse Benefit Determination**
- A revised notice of **Final External Review Decision**

NOTE: Employers with non-grandfathered plans should review existing contracts with insurers and TPAs to ensure compliance with the new mandates and perhaps to confirm liability allocation for failures to meet the new requirements. Care should be taken to update notices and claim/appeals procedures.

KEY CONTACTS

U.S. HUMAN CAPITAL PRACTICE OFFICE LOCATIONS

NEW ENGLAND

Auburn, ME
207 783 2211

Bangor, ME
207 942 4671

Boston, MA
617 437 6900

Burlington, VT
802 264 9536

Hartford, CT
860 756 7365

Manchester, NH
603 627 9583

Portland, ME
207 553 2131

Shelton, CT
203 924 2994

NORTHEAST

Buffalo, NY
716 856 1100

Cranford, NJ
908 931 3005

Florham Park, NJ
973 410 4622

Morristown, NJ
973 829 6374
973 829 6465

New York, NY
212 915 8802

Norwalk, CT
203 523 0501

Radnor, PA
610 254 7289

Wilmington, DE
302 397 0171

ATLANTIC

Baltimore, MD
410 584 7528

Bethesda, MD
301 581 4261

Knoxville, TN
865 588 8101

Memphis, TN
901 248 3103

Nashville, TN
615 872 3716

Norfolk, VA
757 628 2303

Reston, VA
703 435 7078

Richmond, VA
804 527 2343

Rockville, MD
301 692 3025

SOUTHEAST

Atlanta, GA
404 224 5000

Birmingham, AL
205 871 3300

Charlotte, NC
704 344 4856

Gainesville, FL
352 378 2511

Greenville, SC
704 344 4856

Jacksonville, FL
904 355 4600

Marietta, GA
770 425 6700

Miami, FL
305 421 6208

Mobile, AL
251 544 0212

Orlando, FL
407 562 2493

Raleigh, NC
704 344 4856

Savannah, GA
912 239 9047

Tallahassee, FL
850 385 3636

Tampa, FL
813 490 6808
813 289 7996

Vero Beach, FL
772 469 2842

MIDWEST

Appleton, WI
414 259 8837

Chicago, IL
312 288 7700
312 621 4843
312 348 7678

Cleveland, OH
216 861 9100

Columbus, OH
614 326 4722

East Lansing, MI
517 349 3226

Grand Rapids, MI
248 735 7249

Green Bay, WI
414 259 8837

Milwaukee, WI
414 203 5248
414 259 8837

Minneapolis, MN
763 302 7131
763 302 7209

Moline, IL
309 764 9666

Pittsburgh, PA
412 645 8506

Schaumburg, IL
847 517 3469

SOUTH CENTRAL

Amarillo, TX
806 376 4761

Austin, TX
512 651 1660

Dallas, TX
972 715 2194
972 715 6272

Denver, CO
303 765 1564
303 773 1373

Houston, TX
713 625 1017
713 625 1082

McAllen, TX
956 682 9423

Mills, WY
307 266 6568

New Orleans, LA
504 581 6151

Oklahoma City, OK
405 232 0651

Overland Park, KS
913 339 0800

San Antonio, TX
210 979 7470

Wichita, KS
316 263 3211

WESTERN

Fresno, CA
559 256 6212

Irvine, CA
949 885 1200

Las Vegas, NV
602 787 6235
602 787 6078

Los Angeles, CA
213 607 6300

Novato, CA
415 493 5210

Phoenix, AZ
602 787 6235
602 787 6078

Portland, OR
503 274 6224

Rancho/Irvine, CA
562 435 2259

San Diego, CA
858 678 2000
858 678 2132

San Francisco, CA
415 291 1567

San Jose, CA
408 436 7000

Seattle, WA
800 456 1415

The information contained in this publication is not intended to represent legal or tax advice and has been prepared solely for educational purposes. You may wish to consult your attorney or tax adviser regarding issues raised in this publication.