



Benefit Trends

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Health Care Reform – Special Edition

Health Care Reform: Claims Appeals Process Part II

External Claims Appeals

LEGISLATIVE BRIEF

July 30, 2010

On July 23, 2010 we discussed the HCR (Health Care Reform) Agencies' (Department of Labor, Health and Human Services, and Treasury) Interim Final Rule on claims appeals processes with attention paid to the rules applicable to appeals made and reviewed by the group health plan internally. For insured plans, the insurer must meet the Rule's standards. For self-insured plans, the plan sponsor/named fiduciary (i.e. the plan administrator under the Employee Retirement Income Security Act (ERISA)) must meet these rules. For non-ERISA self-funded plans (e.g. those sponsored by churches or public agencies) the burden of compliance falls on the church or agency sponsoring the plan.

Effective Date

Both the internal review and external review processes will apply beginning with the first day of the plan year beginning on or after September 23, 2010 and are applicable to non-grandfathered plans only. For states without a current insured plan external review mechanism, plans will be given until July 1, 2011 to enact the necessary legislation to create such a mechanism. HCR law allocates \$31 million in grants available to states for instituting or upgrading their external review process. These new rules apply to adverse determinations made on or after the first day of the plan year of the non-grandfathered plan occurring on or after September 23, 2010.

The Model Act

As we mentioned in our previous briefings the National Association of Insurance Commissioners (NAIC) has created a [Uniform Model Act](#) on claims review. The Interim Final Rule requires that the state external review process provide, at a minimum, the consumer protections contained in

the NAIC model as of July 23, 2010 (the date the HCR Agencies published the Interim Final Rule on the subject). Insurers doing business in a state that meets these standards must provide external reviews using the state external review process. Similarly, non-ERISA self-funded plans must allow for external review using the state review process if it meets the NAIC standards. Please refer to our previous update for a description of these consumer protections under the NAIC model.

Non-complying States

Insurers and self-funded plan sponsors in states where the external review process does not meet the NAIC standards as of July 1, 2011 must comply with a federal external review process. Agencies also may deem existing state external review processes or insurer or self-funded health plan external processes as compliant as long as they were in effect on March 23, 2010.

Additional State Standards

In addition to containing the NAIC consumer protections, the state external review process must also meet the following standards:

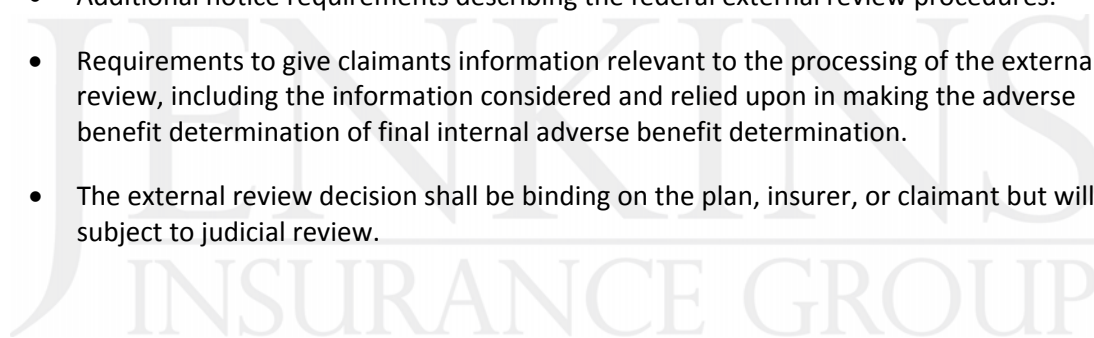
- The review must apply to adverse determinations involving:
 - Medical necessity
 - Appropriateness
 - Health care setting
 - Level of care
 - Effectiveness of a covered benefit
- The state must provide effective written notice to claimants on their rights in connection with the external review process (using the same language requirements as applicable under the internal review process).
- Suspension of the rules on exhaustion of remedies under certain conditions.
- The issuer or the self-funded health plan must pay the cost of the independent review organization (IRO) which will conduct the external review; however, the state may charge a nominal fee to the claimant (not to exceed \$25.00) which must be refunded if the original decision is reversed. The state may waive the fee if it is a financial hardship.
- The state may not impose a minimum threshold for claims under review.
- Claimants must have four months from receipt of the adverse determination to file for the external review.
- The state must assure the independence of the IRO assigned to review the adverse determination. The Interim Final Rule prohibits the issuer, the health plan, or the individual from picking the organization to be used. The IRO also must not have a conflict of interest.
- The state must maintain a list of IROs based on the nature of the claim or service, and accredited by a nationally recognized private accrediting organization.

- The State must allow a claimant five (5) business days to provide additional information in writing to the IRO; the state must notify the issuer or the self-funded plan accordingly within 24 hours of receipt of the additional information.
- The decision must be binding on all parties except to the extent that there are judicial remedies.
- The IRO must provide written notice to the issuer or to the self-funded plan, as applicable, within 45 days of the claimant's request for review.
- The process also must provide for expedited reviews (in the case of emergency services, etc.) within 72 hours of receipt of the request.
- The states must require issuers or, if applicable, the self-funded plans to include a written description of the external review process in or attached to the relevant summary plan description, certificate, insurance policy, or evidence of coverage documents provided to plan participants.

The Federal External Review Process

Insured and self-insured ERISA plans not subject to the state external review process either because the state's process is not compliant or the state has no jurisdiction (in case of self-funded ERISA plans), must comply with the federal external review process. The Agencies will provide additional guidance on the federal process; however, in the meantime, the Interim Final Rule states that the federal process will be similar to the NAIC model and include the following:

- A description of how a claimant may initiate an external review.
- Procedures for preliminary review to determine whether a claim is subject to external review, minimum qualifications for the IRO.
- A process for approving IROs to conduct external reviews, and a process for random assignment of external review to approved IROs.
- Standards for IRO decision making.
- Rules for providing notice of final decisions.
- Expedited review requirements to protect the health of the claimant.
- Consumer protections to ensure that adequate clinical and scientific experience and protocols are considered for claims involving experimental or investigational treatments.
- Additional notice requirements describing the federal external review procedures.
- Requirements to give claimants information relevant to the processing of the external review, including the information considered and relied upon in making the adverse benefit determination of final internal adverse benefit determination.
- The external review decision shall be binding on the plan, insurer, or claimant but will be subject to judicial review.



Action Plan

1. For non-grandfathered insured plans, sponsors need only to confirm that the insurer will meet the requirements of the Interim Final Rule as of the first day of the insured plan's plan year. If the plan renewal date and the plan year start date are different, determine the insurer's stance of when the rule will apply (most likely the state's external procedure which may apply currently).
2. For non-grandfathered self-insured plans, or for public agency or church plans, the plan sponsor must bear the major burdens of implementation of the rule, especially with regard to the notice requirements. The sponsor must look for further guidance.
3. Employers with a large (25% or more) non-English speaking population must assure that the insurer or, in the case of the self-funded plan, provide notices in the second language.

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