



Benefit Trends

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Health Care Reform – Special Edition

Health Care Reform: Claims Appeals Processes

LEGISLATIVE BRIEF

July 23, 2010

With a continuing show of urgency, the Departments of Labor and Health and Human Services, along with the Department of Treasury (Agencies) have now published their sixth Interim Final Rule in less than three months. For the most part these rules are applicable to Health Care Reform provisions becoming effective for group health plans for plan years beginning on or after September 23, 2010 (also applicable to individual health policies renewed or effective on or after September 23, 2010).

In brief, the new Appeals Rule augments and expands the Department of Labor (DOL) claims and appeals regulations originally promulgated in 2000 governing group health plans subject to the Employee Retirement Income Security Act of 1974 (ERISA). These expanded rules will now be applicable to plans sponsored by churches and public agencies even though they are not subject to ERISA. These new rules do not apply to grandfathered plans.

The Expansion and Its Effects

The Interim Final Regulations issued July 22, 2010 contain six new rules. The purpose of this Memorandum is to discuss each of these six new rules.

1. **The Definition of an Adverse Benefit Determination.** In brief, a failure by the plan to pay the total amount of expenses submitted in whole or in part or a rescission of coverage constitute an adverse benefit determination. Adverse benefit determinations which become eligible for internal review and appeal include the following:
 - A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:
 - A determination of an individual's eligibility to participate in a plan or health insurance coverage;
 - A determination that a benefit is not a covered benefit;

- The imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or,
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

As you may recall, Health Care Reform prohibits retroactive policy rescissions (other than for non-payment of premiums) except in the case of fraud or an intentional misrepresentation of fact.

2. **Duty to Provide Notice.** This Interim Final Rule modifies the existing notice requirements contained in the current DOL claims and appeals procedures regulations, in the case of a claim involving urgent care, by accelerating adjudication to occur no later than 24 hours after receipt of a claim containing sufficient information to allow for its adjudication. This replaces the old DOL standard of 72 hours. According to the Rule's preamble, the Agencies agreed to change this rule in light of today's advanced electronic communications capability.
3. **Full and Fair Review.** Since the issuance of the original DOL rule, the DOL has asserted that claimants have a right to review any "new or additional evidence" the reviewer may consider or rely upon in its decision on the claim. There are numerous court holdings to the contrary (i.e. that the claimant has no "right" per se to review and respond to this new evidence (e.g. additional doctor's reports, experts' written statements etc.) The new Rule requires the reviewer to provide the claimant with any new evidence as soon as possible and sufficiently in advance of the reviewer's statutory date for a decision (usually 60 days), to allow time for the claimant to respond to or refute the new evidence. If the reviewer intends to base an adverse ruling on this new evidence, he/she must provide the rationale to the claimant in advance and must allow the claimant reasonable time to respond prior to issuance of the denial.
4. **Conflicts of Interest.** The plan or issuer must ensure that all claims are adjudicated in an impartial manner. In the event the plan or issuer hires an expert, for example, the decision about whom to hire must not be based on the likelihood the expert will support the denial of benefits. Additionally, a plan or issuer must not pay bonuses to the claims examiners based on the number of claims denials he or she generates.
5. **Notices to Enrollees.** The new Rule requires that plans and issuers must issue all claims-related notices to enrollees in a culturally and linguistically appropriate manner. In addition to the requirement that a notice be written in a manner that is easily understood by plan participants, it also must be in the appropriate language when 25% or more of all plan participants are literate in that language, for plans with less than 100 participants at the beginning of the plan year, and for plans with more than 100 participants, the lesser of 500 participants or 10% of all plan participants being literate in a non-English language. The notice in English must contain a prominently placed statement in the foreign language indicating the availability of the notice in that language.

As required under the DOL current regulations, the notices also must contain enough information to identify the claim involved, date of services, provider, claim amount, as well as the diagnosis code with their meanings. Under the new Rule, the notice also must contain a description of the reviewer's standard, if any, used in denying the claim, such as medical necessity. Notices regarding appeals must include a narrative discussion of that decision and a description of the available internal and external appeals processes and how to access them. As required by most state laws, the notice must also provide the contact information for any applicable reviewing agency, including the new state-level consumer assistance

agency established under Health Care Reform. We understand that the Agencies will provide model notices shortly.

6. **Flawed Reviews and External Review Options.** In the event that a plan or issuer fails to adhere to all the requirements of the rules for claims appeals, regardless of how minimal, a claimant may seek an External Review and pursue judicial review (i.e. ERISA Section 502(a)). The Rule also requires that plans/issuers continue to provide coverage during the pendency of such reviews.

External Reviews

In addition to expanding the scope of the DOL claims procedures, Health Care Reform creates a new External Review process. The Health Care Reform law requires that plans and issuers must comply either with a state External Review process or the federal review process. The Interim Final Rule provides the basis for determining which review process will apply based on an extensive set of criteria related to consumer protections. In summary, claimants whose appeal has been denied, have a right to have an independent reviewer (i.e. someone not employed by the health plan). Although the National Association of Insurance Commissioners has adopted a model External Review process, not all states have adopted it. The Interim Final Rule gives states until July 1, 2011 to adopt the NAIC model. In brief, the NAIC model contains the following rules:

- **External review of plan decisions** to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- **Clear information** for consumers about their right to both internal and external appeals - both in the standard plan materials, and at the time the company denies a claim.
- **Expedited access** to External Review in some cases - including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
- **Health plans must pay the cost of the external appeal** under State law, and States may not require consumers to pay more than a nominal fee.
- **Review by an independent body** assigned by the State. The State must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
- **Emergency processes for urgent claims** and a process for experimental or investigational treatment.
- **Final decisions must be binding** so, if the consumer wins, the health plan is expected to pay for the benefit that was previously denied.

At present, if state laws do not contain these standards, claimants covered under insured plans may pursue remedies under the federal rules. Since state laws typically don't have jurisdiction over self-insured plans (other than MEWAs), claimants under these plans also may seek protection under the federal rule. We will discuss the External Review process in greater detail in a subsequent briefing.

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