Internal Appeals and External Review Processes under the Affordable Care Act

Mark L. Stember, Esq, Kilpatrick Stockton LLP

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On July 22, 2010, the Departments of Labor, Treasury and Health and Human Services (the "Departments") issued another round of guidance implementing the Affordable Care Act group health plan provisions. The interim final rules (the "Rules") address the provisions of the Affordable Care Act relating to the internal claims and appeals and external review processes under Section 2719 of the Public Health Service Act. These requirements apply only to non-grandfathered health plans as of the first plan year beginning after September 23, 2010 (for calendar year plans, January 1, 2011). This Alert addresses only those provisions in the Rules concerning group health plans and health insurance coverage sponsored by employers. However, it does not address the provisions in the Rules that relate to individual health coverage.

Although group health plans subject to ERISA must already comply with uniform standards for handling claims and appeals for benefits, the Rules provide additional requirements that must be incorporated into these internal claims procedures. One major change for group health plans is that the Rules add a right to appeal decisions to an outside, independent reviewer either pursuant to a State external review process or, for self-insured plans not subject to those State rules, a federal process.

These procedures will result in greater costs in administering employer health plans and, possibly, an increase in civil actions if there is a failure to follow each additional step required during the claims and review process. Employers with self-funded plans that are not grandfathered plans should review their administrative services agreements to reflect these new procedures and address which party will bear liability for any failure to strictly adhere to these new requirements. Employers currently assessing whether to take the steps necessary to remain a grandfathered plan, at least for 2011, should take these rules into consideration in making that decision.

Internal Claims and Appeals (PHSA Section 2719)

A non-grandfathered group health plan and a health insurance issuer offering group health insurance coverage must incorporate the standards established by the Secretary of the Labor in its internal claims and appeals processes, as described in the Rules. As a baseline, group health plans and group health insurance issuers must follow the DOL claims procedure regulations applicable under ERISA that were issued in 2000 (pursuant to 29 CFR 2560.503-1). In addition, the Rules provide six additional rules to follow, plus a maintenance of coverage rule pending an appeal. Thus, plan sponsors will need to work closely with their third-party administrators to make certain that the new claims and appeals rules are added to non-grandfathered plans for 2011. In addition, because eligibility claims are also subject to the new Rules, plan sponsors may need to revise their internal processes for handling eligibility claims and appeals.

The new internal claims and appeals rules applicable to non-grandfathered plans are as follows –

- ***Determinations Eligible for Internal Claims and Appeals Processes.*** Adverse determinations that are subject to these new claims and appeals processes include a denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including those based on:
    - A determination of eligibility to participate in the plan,
    - A determination that a benefit is not covered,
    - A determination that a benefit is experimental, investigational or not medically necessary or appropriate, or
    - The imposition of a preexisting condition exclusion, source of injury exclusion, network exclusion or other limitation on a covered benefit.

  Any rescission of coverage under PHSA Section 2712 is also subject to the new internal claim and appeal rules, even if there is no immediate effect on a particular benefit at the time of the rescission.
- ***Shorter Period for Providing Notice Regarding Urgent Care Claims.*** The plan must notify a claimant of a benefit determination (whether adverse or not) with respect to urgent care claims as soon as possible, but not later than 24 hours after receipt of the claim, unless sufficient information is not provided to determine whether benefits are covered. Currently, the DOL claims procedures require notification of urgent care claims within 72 hours after receipt of the claim. Interestingly, the preamble notes that technology has improved since the original DOL claims procedures were issued in 2000, thereby allowing for electronic notice. Unfortunately, the DOL has not updated its regulations on notifying individuals electronically, and due to the arcane nature of the regulations many plans do not choose electronic notification.
- ***Advance Information and Opportunity to Respond Prior to Final Decision.*** In addition to the requirements imposed under the DOL's claims procedures, the plan must provide the claimant, at no cost, any new evidence that is considered, relied upon, or generated by the plan in connection with the claim. This information must be proved as soon as possible and sufficiently in advance of the date on which the notice of a decision is required so that the individual has an opportunity to respond prior to that date. Further, before a final internal adverse decision is rendered, the claimant must be provided, free of charge, with the rationale for the decision so that the individual has an opportunity to respond prior to that date.
- ***Avoiding Conflicts of Interest.*** Claims and appeals must be adjudicated in a manner that ensures the independence and impartiality of the individuals making the decision. This means that decisions regarding hiring, compensation, termination, or similar matters cannot be made based on the likelihood that the individual will support the denial of benefits. For example, a plan or issuer cannot hire a medical expert based on that expert's reputation for outcomes in contested cases and cannot provide bonuses based on the number of denials of claims.
- ***Additional Disclosures and Content of Notice***. In addition to the information required to be provided under the DOL's claims procedures, notice of an adverse decision must include the date of service, health care provider, claim amount, diagnosis code, treatment code and the meanings of these codes. The reasons for the adverse decision must also include the denial code (such as the Claim Adjustment Reason Code or Remittance Advice Remark Code) and an explanation of the code. Further, the notice must include a discussion of any plan standard used in the determination (e.g., medical necessity), a discussion of the claim and appeal procedures, and the contact information for any applicable consumer assistance office established under the PHSA Section 2793 to assist enrollees with these procedures. Although model notices will be issued in the near future, it is clear that the

EOBs used by most third party administrators today will need to be substantially revised, and given the lead time that such revisions entail, it is likely that many plans cannot wait for model notices.

- ***Effect of Failure to Comply***. Failure to *strictly comply* with all the requirements results in the claimant being deemed to have exhausted the claims and appeals procedures which allows the individual to initiate an external review and pursue other applicable remedies, such as bringing legal action. Note that the standard is quite high: substantially complying with the rules or de minimis errors still trigger the deemed exhaustion of the internal procedures. This rule substantially raises the stakes for plans and, to the extent applicable, sponsors should make certain that their third party administrators are complying with the new rules and determine whether their TPAs are or should be contractually liable for any related failures.
- ***Coverage Pending Appeal***. The Rules require a plan to continue coverage pending appeal. For this purpose, the Rules require the plan to follow the ongoing course of treatment provisions in the DOL claims procedures. It is unclear whether the intent is to limit continued coverage to adverse benefit decisions that relate to an ongoing course of treatment or if this requirement will have a broader application. The blanket statement in the Rules that coverage must be continued pending an appeal implies a broad application, but the reference to the current DOL claims procedures and a statement in the preamble that this provision should not have a significant cost impact on plans subject to ERISA indicate otherwise. A broad application of this requirement would be quite troubling, particularly given the fact that eligibility claims and rescissions are subject to the Rules.

External Review (PHSA Section 2719)

In addition to the internal claim and appeal provisions above, plans must also comply with either a State external review process or the Federal external review process.

- ***State Standards for External Review***. If a State external review process satisfies the minimum requirements set forth in the Rules, and the State external review process applies to and is binding on the health insurance issuer of a fully-insured group health plan, the group health plan itself (and the employer maintaining that plan) is required to comply with the State process.

  Typically, fully-insured plans will be required to comply with the State process, provided that process includes, at a minimum, the consumer protections provided in the Rules. To allow States time to amend their laws, the Rules provide for a transition period for plan years beginning before July 1, 2011, where existing State external review processes are deemed to meet these minimum standards. As a result, for plan years beginning before July 1, 2011 (the 2011 plan year for calendar year plans), health insurers subject to an existing State external review process must comply with that process and not the Federal process. An open issue for which comments are sought is how to handle health insurers in a State that does not apply its external review process to all issuers (such as when a State applies its external process only to HMOs). Future guidance addressing this issue is expected.

- ***Federal External Review Process***. Self-insured plans and other plans that do not satisfy the State external review process must comply with the Federal process. These Rules describe the scope of claims eligible for this process but not the process itself (further guidance will be issued on this process). Adverse determinations relating to an individual's failure to meet the requirements for eligibility under the plan are <u>not</u> subject to this external review process. However, the Rules do provide that the additional standards and guidance that will be issued will provide the following –

  - The standards will describe how a claimant will initiate an external review, procedures for determining whether a claim is eligible for an external review, minimum qualifications for

independent review organizations (IROs), a process for random assignment of reviews to the approved IRO and rules for providing notice of the final external review decision.

- An expedited external review process will be available if there is serious jeopardy to the life or health of the claimant or if the internal adverse decision concerns an admission, continued stay or health care service for which the individual received emergency services and has not been discharged from the facility.
- Additional consumer protections will be provided to ensure that adequate clinical and scientific experience and protocols are taken into account with respect to claims involving experimental or investigational treatments.
- The external review process will be binding, except to the extent other remedies are available under State or Federal law.
- Additional notice requirements will be provided to inform participants of these external review procedures.

Notices in Languages Other than English

Notices relating to claim and appeal determinations (e.g., EOBs), plus the Federal external appeal notices, must be provided in a non-English language if certain thresholds that relate to the number of people literate in the same non-English language are met.

- ***Thresholds for Group Plans***. For plans that cover fewer than 100 participants at the beginning of the plan year, the threshold is 25% being literate only in the same non-English language. For plans with 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants or 10% of all participants being literate in only the same non-English language. Given these thresholds it is likely that some plans may be required to provide notices in more than one non-English language.

- ***Required Notice***. If this threshold is met, (1) notice must be provided upon request in that non-English language, and (2) the English version of the notice must include a prominent statement in the non-English language offering the additional notice in that other language. Once a participant requests a notice in that language, all future notices must be provided to that individual in such other language.

- ***Customer Assistance in a Non-English Language***. In addition to the non-English language notice, telephone hotlines or other customer assistance regarding claims and appeals must also be provided in that other language (apparently only upon request if the applicable threshold is satisfied).