

# Internal Claims and Appeals and External Review under Health Care Reform

Employers that sponsor non-grandfathered group health plans must comply with significant new rules that affect their plans' internal claims and appeals process and require a detailed external review procedure. Agency guidance addressing these changes was released over the past year, including regulations issued in June 2011 that amend several requirements.



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Under the Employee Retirement Income Security Act of 1974 (ERISA) and related Department of Labor (DOL) claims regulations, benefit plans, including group health plans, must establish and maintain internal procedures that permit participants and beneficiaries to:

- Make claims for benefits.
- Appeal a plan's or insurer's benefits denial (sometimes called an adverse benefit determination), which may involve one or more levels of review.

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together known as health care reform) add new requirements to the claims and appeals process for non-grandfathered group health plans and insurers (in both the group and individual markets). In addition to these internal plan procedures, health care reform generally requires external review of many denied claims, which must occur under either a state or federal external review process.

Subject to certain transition rules, the new internal claims and appeals requirements generally apply:

- To plan years beginning on or after September 23, 2010.
- On January 1, 2011 for plans that operate on a calendar-year basis.

Implementing guidance for the requirements, jointly issued by the DOL, Internal Revenue Service and US Department of Health & Human Services (collectively, the Agencies), includes interim final rules (IFR) issued in July 2010 and amendments to the IFR (Amendments) issued in June 2011. The internal claims and appeals and external review requirements have also been addressed in numerous technical releases, frequently asked questions, model notices and related guidance.

This article explains the new rules for the internal claims and appeals process and the external review procedure requirements.

## GRANDFATHERED PLANS

"Grandfathered" health plans under health care reform are not required to comply with the new claims and appeals requirements. A grandfathered plan is coverage:

- Provided by a group health plan or insurer.
- In which at least one individual enrolled on March 23, 2010, the enactment date of health care reform.
- That complies with the requirements set forth in the Agencies' guidance governing grandfathered plans.

## INTERNAL CLAIMS AND APPEALS REQUIREMENTS

Under health care reform, non-grandfathered group health plans and insurers with respect to non-grandfathered policies must implement an effective internal claims and appeals process. This process must take into account the following requirements that were initially described in the IFR and recently updated by the Amendments:

- The definition of "adverse benefit determination" must include coverage rescissions.
- Plans have up to 72 hours to make urgent claim decisions.
- Plans and insurers must provide additional claimant rights.
- Notices of adverse benefit determinations must include additional content provisions.

- Notices must be provided in a non-English language on request if a standardized trigger is met.
- The process must ensure decision makers have no conflicts of interest.
- Plans and insurers must provide continued coverage for certain types of treatments pending the outcome of an appeal.

>> For a Practice Note on the internal claims and appeals rules under health care reform, search [Internal Claims and Appeals under Health Care Reform](#) on our website.

### ADVERSE BENEFIT DETERMINATIONS INCLUDE RESCISSIONS

The IFR expands the definition of an adverse benefit determination under the DOL claims regulations, which were generally applicable to group health claims filed on or after January 1, 2003, to include coverage rescissions, regardless of whether the rescission has an adverse affect on a particular benefit at the time of the decision. Under related health care reform guidance, the Agencies generally define rescission as any retroactive termination of group health plan or health insurance coverage, except where an individual either:

- Performed an act of fraud.
- Made an intentional misrepresentation of a material fact.

Importantly, the Agencies do not treat a retroactive termination of coverage as a rescission when the termination is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

### URGENT CLAIM DECISIONS

The IFR shortened the time period for providing notice of benefit determinations for “urgent” claims, whether adverse or not. Under the IFR, notice was required:

- As soon as possible, taking into account medical exigencies.
- Not later than 24 hours after the plan’s or insurer’s receipt of the claim (reduced from 72 hours under the DOL’s claims regulations).

However, the Amendments:

- Eliminate the IFR’s requirement that urgent claims be decided within 24 hours.
- Generally permit plans and insurers to follow the original rule under the DOL claims regulations.

As a result, urgent claims must be decided no later than 72 hours after receipt of the claim. The plan or insurer must defer to the attending provider’s determination regarding whether a claim is urgent. Individuals in urgent claim situations may request an expedited external review under the applicable state or federal external review process (see below *External Review Process*).

### ADDITIONAL CLAIMANT RIGHTS (FULL AND FAIR REVIEW)

The IFR expands requirements under the DOL claims regulations intended to ensure that claimants receive “full and fair review” of claim denials.

First, under the IFR, plans and insurers must provide claimants free of charge (and not only on request) with any new or additional evidence that is considered, relied on or generated by, or at the direction of, the plan or insurer in connection with the claim. Second, before plans and insurers can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided free of charge (and not only on request) with that new or additional rationale.

The new or additional evidence or rationale, as applicable, must be provided as soon as possible and, in any event, sufficiently before the notice of a final internal adverse benefit determination is due, to give the claimant a reasonable opportunity to respond before that date.

In addition, plans and insurers must allow claimants to:

- Review their claim file.
- Present evidence and testimony as part of the internal claims and appeals process.

### ADDITIONAL CONTENT REQUIREMENTS FOR NOTICES

The IFR includes additional content provisions for notices of adverse benefit determinations. However, the Amendments eliminate some of these requirements. The Agencies have provided an enforcement grace period for certain additional requirements until plan years beginning on or after January 1, 2012.

#### Requirements under IFR

Under the IFR, notices of adverse benefit determinations must include:

- Information sufficient to identify the claim, including the:
  - date of service;
  - health care provider;
  - claim amount, if applicable; and
  - diagnosis and treatment codes, and the corresponding meanings of these codes (although this requirement was changed by the Amendments (see below *Amendments Eliminate Diagnosis and Treatment Codes Requirement*)).
- A description of the reason(s) for the denial, including:
  - the denial code and corresponding meaning;
  - a description of the plan’s or insurer’s standard, if any, applied in denying the claim (for example, if a plan used a medical necessity standard in denying a claim, the notice must describe the medical necessity standard); and

- a discussion of the decision for final internal benefit denials.
- A description of available internal appeals and external review procedures, including information on how to initiate an appeal.
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and appeals and external review procedures.

### Amendments Eliminate Diagnosis and Treatment Codes Requirement

The Amendments eliminate the IFR's requirement to automatically provide diagnosis and treatment codes, and their corresponding meanings, as part of benefit denials, including explanation of benefit (EOB) statements.

Instead, plans and insurers must:

- Provide a statement describing the opportunity to request the diagnosis and treatment codes (and their meanings) in all benefit denial notices, including EOBs.
- Furnish this information as soon as practical on request.

Updated model notices issued by the Agencies contain language that plans and insurers can use to satisfy this requirement. The Amendments also clarify that a claimant's request for diagnosis or treatment codes is not, in itself, a request for internal appeal or external review.

### Enforcement Grace Period for Content in Notices

The Agencies have provided a two-part enforcement grace period for the additional content requirements for claim denial notices.

First, the enforcement grace period for the requirement to disclose diagnosis and treatment codes (and their corresponding meanings) was extended until plan years beginning on or after January 1, 2012. As noted, however, the Amendments eliminate the requirement to provide these codes automatically.

Second, the enforcement grace period for the other components of the new notice requirement was extended to:

- The first day of the first plan year beginning on or after July 1, 2011.
- January 1, 2012 for calendar year plans.

The enforcement grace period applies to:

- The disclosure of information sufficient to identify a claim, other than diagnosis and treatment information.
- The reasons for a benefit denial.
- The description of available internal and external review procedures.
- For plans and insurers in states with an operational office of health consumer assistance program or ombudsman,

disclosure of the program's availability (and contact information).

### STANDARDIZED TRIGGER FOR PROVIDING NON-ENGLISH LANGUAGE NOTICES

Health care reform requires claims and appeals notices to be provided in a "culturally and linguistically appropriate manner." Under the IFR, this requirement is satisfied if notices are provided in a non-English language based on plan size and thresholds as to the number of participants literate in the same non-English language. However, these requirements are significantly modified by the Amendments.

The Amendments create a single standard for when plans and insurers must provide claims and appeals notices in a culturally and linguistically appropriate manner. This standard applies for both the individual and group markets. The requirement to provide notices, on request, in a non-English language is triggered if 10% or more of the population residing in the claimant's county (based on data published by the US Census Bureau) are literate in the same non-English language.

Plans and insurers with claimants residing in the identified counties must include a prominent statement in the applicable non-English language:

- On the English version of all claims and appeals notices.
- Informing individuals about how they can obtain language assistance services in the non-English language.

This disclosure statement may be satisfied by including the following sentence on claims and appeals notices in any applicable non-English language(s): "To obtain assistance in [insert non-English language], call [insert telephone number]."

Additionally, plans or insurers must provide oral language services (such as a telephone customer assistance hotline) where customer service representatives will:

- Answer questions in the applicable non-English language.
- Provide assistance with filing claims and appeals (including external review) in any applicable non-English language.

The Agencies have provided an enforcement grace period for the non-English language notices requirement until plan years beginning on or after January 1, 2012.

### AVOIDING CONFLICTS OF INTEREST

Claims and appeals must be decided in a manner that ensures the independence and impartiality of the individuals involved in the plan's or insurer's decision-making process. The hiring, compensation, termination and promotion and other similar matters regarding individuals must not be made based on the likelihood that an individual will support the denial of benefits. For example, the plan or insurer cannot:

- Provide bonuses based on the number of denials made by a claims adjudicator.

- Contract with a medical expert based on the expert's reputation for outcomes in contested cases, rather than based on the expert's professional qualifications.

### CONTINUED COVERAGE PENDING OUTCOME OF APPEAL

Plans and insurers must provide continued coverage for certain types of treatment pending the outcome of an internal appeal. Under the DOL claims regulations, benefits for an ongoing course of treatment (known as concurrent care claims) cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

## CONSEQUENCES OF NON-COMPLIANCE

### STRICT COMPLIANCE RULE UNDER IFR

Under the IFR, if a plan or insurer does not strictly comply with the internal claims and appeals requirements, the claimant is deemed to have exhausted the internal claims and appeals procedures and may immediately:

- Initiate an external review.
- Pursue any available remedies under ERISA or state law (for example, review by a court).

Under the IFR, the strict compliance rule applies even where a plan or insurer:

- "Substantially complied" with the claims requirements.
- Made a minor error that did not harm or prejudice the claimant.

This is a departure from the prior DOL claims regulations, under which the DOL and some courts recognized that not every deviation from the requirements justified proceeding to court.

The Agencies have provided an enforcement grace period for this requirement until plan years beginning on or after January 1, 2012.

### LIMITED EXCEPTIONS TO STRICT COMPLIANCE RULE

The Amendments modify the IFR rule by providing that internal claims and appeals procedures will not be deemed exhausted based on violations that are:

- *De minimis*.
- Non-prejudicial to the claimant.
- Attributable to good cause or matters beyond the plan's or insurer's control.
- In the context of an ongoing, good faith exchange of information between the claimant and the plan.
- Not reflective of a pattern or practice of violations by the plan or insurer.

## PRACTICAL CONSIDERATIONS FOR PLANS AND INSURERS

To comply with internal claims and appeals and external review requirements, plans and insurers should:

- Determine whether the new claim and appeal rules affect the decision to maintain grandfathered plan status.
- Update claim denial forms and notices to reflect the new requirements.
- Review and update descriptions of claims procedures in plan documents and summary plan descriptions.
- Consult the current US Census Bureau list to determine whether they have claimants residing in counties that meet the 10% threshold for providing notices in a culturally and linguistically appropriate manner, and modify their benefit denial notices accordingly.
- Contract with IROs to provide external review, if applicable.
- Identify claim denials involving "medical judgment" that are subject to external review, and for which notice of external review rights must be disclosed to claimants.

The Amendments permit claimants to request a written explanation of any violation from the plan or insurer. On receiving a request, the plan or insurer must:

- Provide the explanation within ten days.
- Include a specific description of its grounds, if any, for asserting that the violation should not cause the internal claims and appeals procedures to be deemed exhausted.

If a claimant nonetheless skips the internal appeals process and files for external or judicial review, the external reviewer or court may reject the claimant's attempt at immediate review on the basis that the plan's or insurer's violation was *de minimis*.

## EXTERNAL REVIEW PROCESS

Health care reform requires non-grandfathered group health plans and insurers to comply with either a state or federal external review process.

### APPLICABLE EXTERNAL REVIEW PROCESS

The applicable external review process generally depends on whether the coverage is under a self-insured or insured plan.

#### Self-insured Plans

In a self-insured plan, the employer generally:

- Assumes most or all of the cost of health insurance for their employees.
- Pays for each claim as it is incurred instead of paying a premium to an insurer.

For self-insured ERISA plans, a federal external review process applies, although plans may voluntarily comply with a

state external review process, if available. In 2010, the DOL provided an enforcement safe harbor allowing for a private contract process under which self-funded ERISA plans could contract with accredited independent review organizations (IROs) to perform external reviews.

### Insured Plans

For insured plans (and self-funded non-ERISA plans, such as church plans and non-federal governmental plans), if a state external review process that includes certain minimal consumer protections under the National Association of Insurance Commissioners (NAIC) Uniform Model Act applies to and is binding on the insurer and the plan, then the insurer or plan must comply with the state external review process and not the federal process. The IFR provides a transition period, which was extended from July 1, 2011 until December 31, 2011, during which any state external review process is considered sufficient (even if it did not satisfy the minimum criteria specified in the IFR).

Federal external review process applies to insurers and non-ERISA plans in states and US territories:

- Without any external review requirements.
- Where external review standards do not satisfy minimum requirements during a pre-2014 transition period.

### MODIFICATIONS TO EXTERNAL REVIEW RULES UNDER AMENDMENTS

The Amendments make several changes to the IFR external review rules.

#### Scope of Federal External Review

The Amendments narrow the scope of appeals that are subject to external review under the federal process generally applicable to self-funded ERISA plans. Under the IFR, “any” adverse benefit determination (other than one involving eligibility) is subject to external review. This includes claims involving purely contractual issues, such as:

- Whether a procedure was excluded from coverage.
- The amount of cost-sharing applicable to a procedure.

The Amendments “suspend” this aspect of the IFR and provide that during this suspension period, only claims involving medical judgment and rescissions are subject to federal external review. The Amendments define “medical judgment” to include claims for:

- Medical necessity.
- Appropriateness of care.
- Health care setting.
- Level of care.
- Effectiveness of a covered benefit.

- Determinations as to whether a treatment or procedure is experimental or investigational.

The Agencies view the following as claims involving medical judgment, although the plan or insurer may not issue an adverse benefit determination in connection with its decision:

- Determinations as to the applicability of a plan’s preexisting condition exclusion.
- Determinations regarding the availability of an alternative standard to qualify for a wellness program reward.

Importantly, the Amendments state that the determination of whether a claim involves a medical judgment is made by the external reviewer. This suggests that the IROs with which the plan contracts will make the ultimate decision about whether a claim is eligible for external review.

#### Safe Harbor for IROs

Under guidance accompanying the Amendments, the DOL and IRS modified the enforcement safe harbor regarding IROs. Under this guidance, self-funded plans (or third-party administrators for these plans) will be eligible for the safe harbor if they have contracted (to perform external review) with at least:

- Two IROs by January 1, 2012.
- Three IROs by July 1, 2012.

Plans must also rotate external review claims among their contracted IROs to minimize the risk that one IRO may become dependent on the plan. Plans may use an alternative process to satisfy the random assignment process, but the DOL and IRS will closely examine any process other than rotational assignment.

#### Timing of Benefits Following External Review Decision

The Amendments clarify that plans or insurers must provide benefits following a final external review decision without delay. A plan or insurer cannot refuse to provide benefits on the grounds that it intends to challenge the decision in court. However, a court decision contrary to the final external review decision would be a basis for not providing benefits.