



Federal Health Care Reform Implementation of Regulations Issue Number 4: Claims & Appeals Processes and Regulatory Update

This is the fourth in a series of *Federal Health Care Reform Compliance Bulletins* that **Health Plans** is issuing as the provisions of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or health care reform) are implemented. This edition focuses on:

- **Revised Claims and Appeals Processes:** Step 1 of implementing the new rules
- **Regulatory Update:** Clarifications and changes to previously issued regulations (page 7)

Since our last *Compliance Bulletin* was issued on October 6, 2010, the country has been through national mid-term elections. The One Hundred Twelfth Congress of the United States convened on January 3, 2011. With this in mind, please remember that the information contained in our health care reform *Bulletins* is based on **Health Plans'** understanding of the rules and regulations under the Affordable Care Act as of the dates the *Bulletins* are issued.

The new Congress may bring changes to provisions currently in effect. If and when any new legislation that modifies or revokes the Affordable Care Act is enacted into law, we will update you to describe its potential impact on your plan(s). In the meantime, we will continue to provide you with information about the currently applicable provisions that may affect your plan(s).

Revised Claims and Appeals Processes – Apply to Non-Grandfathered (NGF) Plans Only

(There are no changes to the claims and appeals processes for grandfathered plans.)

Under the Affordable Care Act, new Internal Claims and Appeals and External Review Processes Rules were issued on July 23, 2010 with additional Claims/Appeals Guidance issued on August 26, 2010. The new Rules create a system of checks and balances designed to provide individuals with increased access to internal and external appeals processes. The Rules require NGF health plans to continue to comply with the existing (pre-health care reform) ERISA claims and appeals requirements and extend these requirements to non-ERISA plans. The Rules also require all NGF plans (including non-ERISA plans) to comply with additional provisions which significantly expand the claims and appeals processes.

The first four provisions listed below take effect beginning with the first plan year that starts on or after September 23, 2010. The Department of Labor (DOL) provided a grace period until July 1, 2011 for implementing the last three changes. We will address those provisions in a future *Compliance Bulletin*.

1. **Treat a rescission of coverage as an “adverse benefit determination”:** Rescissions require 30-day advance notice and are subject to the internal appeals process (see page 2);
2. **Expand the full and fair review requirements in the appeals process:** Plans must automatically disclose new or additional evidence considered in claim denials (see page 3);
3. **Provide continued coverage pending the outcome of an appeal:** This requirement is new only for non-ERISA plans (see page 3);
4. **Provide a third, external review upon a claimant’s request:** After final internal appeal, claim denials may be referred to an IRO (independent review organization) at the claimant’s request; if the IRO reverses the denial, the plan must immediately authorize or pay for the services (see pages 4-7);
5. Expand the prescribed content for notices of adverse benefits determinations, including the Explanations of Benefits;
6. Reduce the timeframe for responding to initial urgent care claims; and
7. Add foreign language requirements under certain circumstances.

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Rescissions as Adverse Benefit Determinations

The new Rules define an “adverse benefit determination” in the same manner as under the existing ERISA claims regulations whereby a denial, reduction, termination or failure to make payment (in whole or in part) for a benefit is an adverse benefit determination that must be eligible for an internal claims and appeals process.

However, the new Rules expand this definition to include a rescission of coverage. This change means that for the first time, claims for eligibility alone (not necessarily tied to a specific claim for benefits) will be subject to a plan’s internal claims and appeals procedures. An individual whose coverage has been rescinded must be given notice and an opportunity to appeal the determination.

Which retroactive terminations fall within the definition of “rescission”? The Rules provide that all retroactive terminations of coverage should be treated as rescissions, unless:

- The member (either employee or covered dependent) has engaged in fraud or deliberate misrepresentation of material fact, or
- Premiums had not been timely paid for the coverage.

This requirement presented administrative problems for employer plans because routine coverage terminations are often processed in batches on a periodic schedule, resulting in retroactive terminations. In these cases, the terminated individuals would not have engaged in fraud or misrepresentation, and would not have failed to timely pay premiums. The initial Rules seemed to indicate that the plan could be compelled to either provide coverage until the date the termination was actually processed or give the individual notice of the termination and appeal rights.

To address these problems, the Department of Health and Human Services (HHS) issued a FAQ on October 13, 2010 (FAQ II), clarifying that certain administrative retroactive terminations would **not** be considered rescissions. If, for example, a retroactive termination of a former employee was due to a delay in administrative record-keeping, it will not be considered a rescission as long as the employee had paid no premiums for the coverage. Similarly, for plans that terminate spousal coverage upon divorce, a retroactive termination because the plan was not notified of the divorce will **not** be considered a rescission, provided neither the employee nor the spouse has paid for the coverage.

Other retroactive terminations should still be treated as rescissions in accordance with the Rules. As such, Plan Administrators must provide members whose coverage will be rescinded with at least 30 days’ advance written notice and information about the option for internal appeal.

Implementation

Health Plans’ actions

Health Plans will continue to terminate members’ coverage based on our clients’ direction to do so.

Employer’s actions

Continue to notify **Health Plans** of coverage terminations as soon as administratively possible.

In cases where your plan must rescind coverage for any member, you will need to provide 30 days written notice to the member before instructing **Health Plans** to terminate coverage. Please refer to our October 6th *Bulletin*, which was sent with a sample notice you can adapt and use to notify members of a rescission.

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Changes to the Internal Appeals Procedures

The new Rules also made the following changes to the internal appeals process:

- **Continued Coverage Pending Appeal Outcome**

Plans are required to continue coverage during the appeal process, pending the outcome of the review. However, it currently appears that this requirement is intended to be consistent with the existing ERISA claim regulations for claims involving concurrent care. That is, if an ongoing course of treatment has been approved for a specified period of time or number of treatments, plans cannot reduce the period/number without first providing the claimant with advance notice and the opportunity to appeal. Otherwise, there appears to be no requirement to continue coverage while the appeal process is underway.

Implementation

Health Plans' and Employer's actions: No new actions are required at this time, pending any further guidance from the implementing agencies.

- **Expanded Full and Fair Review Requirements**

Under the existing ERISA claims regulations, claimants who appeal adverse benefit determinations must be given the opportunity to submit comments, documents and records relating to the claim and to receive, upon request and free of charge, access to and copies of all documents, records, and information relating to the claim.

Under the new Rules, plans must:

1. Allow claimants to review the file and present evidence and testimony as part of the internal appeals process; and
2. Take affirmative action to automatically (and free of charge) provide a claimant with any:
 - New or additional evidence considered in connection with the claim as part of the appeals process, and
 - New or additional rationale that would be used to deny an appeal.

The new or additional evidence or rationale must be provided to the claimant:

- As soon as possible, and
- Sufficiently in advance of the deadline for making the appeal determination so that the claimant will have reasonable opportunity to respond before the decision deadline.

Implementation

Health Plans' actions

Health Plans will implement the automatic disclosure requirements as applicable for appeals received on behalf of our clients' plans.

Employer's actions

As the Plan Administrator, **Health Plans** refers all final internal appeals to you for decision. If you have any new or additional evidence or rationale to consider during a final internal review, you should immediately notify your **Health Plans** Account Manager so that we may coordinate the automatic disclosure to the claimant.

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New External Review Processes

• Overview

The new Rules require self-funded ERISA plans to comply with a new federal external review process for claim appeals, incorporating both standard and expedited reviews. Self-funded non-ERISA plans must also comply with the new federal external review processes if either they are not subject to a state requirement for external review or the applicable state process does not meet the minimum requirements of the Affordable Care Act.* Note: Most insured plans are already subject to a state external review process.

In order to comply with the new external review process, self-funded plans must follow interim safe harbor procedures which will remain in effect until they are superseded by future guidance, projected to be issued by July 1, 2011. The safe-harbor procedures are based on the National Association of Insurance Commissioners (NAIC) Model Act and are intended to be similar to the requirements for state external reviews. These procedures are described below.

*Although self-funded plans are permitted to comply with a state review process that meets the minimum standards under the new Rules, it is unlikely that states will permit self-funded plans to access their external review processes. Moreover, it is impractical for multi-state plans to comply with multiple states' external review processes.

• Requirement for Independent Review Organizations

To provide an external review process, plans must contract with at least three independent review organizations (IROs) which are accredited by URAC or by a similar nationally-recognized accrediting organization. External reviews must be sent on a rotating basis or by random selection to one of the three IROs.

The plan (not the claimant) must bear the cost of the IRO review, and an IRO cannot be eligible for any financial incentives based on the likelihood that it will uphold the plan's denial of benefits.

IROs are required to make *de novo* reviews of all claims submitted for review. *De novo* review means that the IRO must consider all the evidence presented and reach its own conclusion, giving no weight to the plan's conclusions or determinations on the earlier claim or appeal(s) denials. The IRO is also required to obtain legal advice where it deems such advice is necessary to make a determination.

• Standard External Review Process

Here is a summary of the standard external review process:

- ◇ **Request for External Review:** Plans must allow a claimant to file a request for external review up to four months after the date of receipt of an adverse benefit determination or final adverse benefit determination (i.e., a final plan determination denying a claim). Note: External reviews are intended to be allowed only after the claimant has exhausted the plan's internal appeals procedures. Since most plans allow for two levels of internal appeal, the external review would be available only after the denial was upheld on the second appeal. However, the Rules also allow a claimant external review if: i) the plan does not respond to an internal appeal within the prescribed timeframes established under the existing ERISA claims and appeals procedures, and ii) the expedited external review process is warranted as described on page 6.
- ◇ **Preliminary Review:** Within 5 business days following receipt of the claimant's request, the plan must complete a preliminary review to confirm that:
 - ◆ The claimant was covered under the plan at the time the service was requested or provided;
 - ◆ The denial does not relate to the claimant's failure to meet the plan's eligibility requirements. (Note: external review is not available for claims based on an eligibility determination, including rescissions);
 - ◆ The claimant has exhausted any internal appeal process required by the plan;
 - ◆ The claimant has provided all information required to process an external review.

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Standard External Review Process, *cont'd*

- ◇ **Confirmation of Eligibility for External Review:** Within one business day after completion of the preliminary review, the plan must issue a written notice to the claimant indicating whether the claim is eligible for external review.
 - ◆ If the request is complete, but the claim is not eligible for external review, the notice must include the reasons the claim is ineligible and the contact information for the Employee Benefit Security Administration (EBSA).
 - ◆ If the request for review is incomplete, the notice must describe the information necessary to make the request complete and allow the claimant to submit additional information by the later of: a) the four month filing period for external review; or b) the 48-hour period following the claimant's receipt of the notice indicating that the request is incomplete.
- ◇ **Referral to an Independent Review Organization:** If a claim is determined to be eligible for external review, the plan must refer it to an IRO on either a random or rotating basis.
 - ◆ All documents and information that were considered in making the denial must be provided to the IRO within 5 business days of referring the request for review. If the required information is not provided by the deadline, the plan cannot request a delay of the external review. In such cases, the IRO may terminate the review and reverse the plan's denial. If the plan's denial is reversed for this reason, the IRO must provide notice to both the plan and the claimant within 1 business day.

If the plan meets the 5-day deadline described above:

- ◆ The IRO must provide timely ("timely" is not defined in the regulations) written notice to the claimant of the claim's eligibility and acceptance for external review, including a statement that the claimant may submit in writing, within 10 business days, additional information for the IRO to consider.
- ◆ The IRO must provide the plan any information received from the claimant within 1 business day of receipt. The plan may then reconsider its denial and, if reversed, the plan must notify the claimant and the IRO within 1 business day.
- ◆ In the absence of an earlier reversal of the plan's decision by either the plan or the IRO, the IRO must provide written notice of its decision to both the claimant and the plan no later than 45 days after the IRO initially received the request for review. The notice must include:
 - A statement that the IRO's decision is binding, except to the extent that other remedies under federal or state law are available to either the plan or claimant, and
 - A statement that judicial review of the decision may be available to the claimant.

A Model Notice of Final External Review Decision which satisfies these requirements has been issued by the federal agencies.
- ◆ If the IRO reverses the plan's denial, the plan must immediately provide coverage or payment of the claim.

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• Expedited External Review Process

An expedited external review allows a claimant to skip the internal review process and/or to accelerate the external review process following a final internal adverse benefit determination in cases where:

- ◆ The time for completing the plan's internal appeals process would seriously jeopardize the claimant's life or health, or ability to regain maximum function; or
 - ◆ The time for completing the standard external review process would seriously jeopardize the claimant's life or health, or ability to regain maximum function, or
 - ◆ The claim involves an admission, availability, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from the facility (i.e., a concurrent care review).
- ◇ **Preliminary Expedited Review:** Immediately upon receipt of a request for expedited external review ("immediately" is not defined in the regulations), the plan must confirm whether the request satisfies the eligibility requirements for a standard external review and immediately send a notice to the claimant advising of the determination.
- ◇ **Expedited Referral to IRO:** If the plan determines that the claim satisfies the requirements for a standard external review and is also eligible for an expedited external review:
- ◆ The plan must assign the claim to an IRO under the standard procedures for random or rotating selection;
 - ◆ The plan must provide all necessary documents and information to the IRO in an expeditious manner (e.g., e-mail, fax, or telephone); and
 - ◆ The IRO must consider the documents and information under the procedures required for a standard external review (i.e., *de novo*, giving no weight to the plan's determination of the claim or appeal(s)).
- ◇ **Notice of Expedited External Review Decision:** The IRO must provide a notice of its determination as expeditiously as the claimant's medical condition or circumstances require, but no more than 72 hours after the IRO receives the request. If the notice is not in writing, the IRO must provide written confirmation of the decision to the claimant and the plan within 48 hours.

The potential benefits of external review: While the new external review process allows claimants one more "bite at the apple" for consideration of a claim denial, this process may reduce the potential for claims litigation. In many cases it may be more attractive for the claimant to pursue an external review than to file suit since an IRO will conduct a review *de novo* at the plan's expense. The impartiality of the IRO may also work to discourage claimants whose denials are upheld from moving on to litigation in the courts. Thus, while the plan sponsor's authority to deny a claim upon final internal appeal can be overturned by the IRO, the external review process may help prevent claimants from filing suit against the plan.

Implementation

Health Plans' actions

Plan Amendment

Effective for plan years beginning on or after September 23, 2010, **Health Plans** will incorporate basic information regarding a claimant's right to external review in the health care reform amendments we are drafting for your plan(s). After the DOL releases model language to be included in Plan Documents/Summary Plan Descriptions that relate to all the claims and appeals changes required by the new Rules (including those to be implemented beginning July 2011), Health Plans will draft a second, more comprehensive amendment for your plan (unless your plan year begins after the date the DOL releases the model language, in which case you will receive one amendment incorporating all of the applicable provisions).

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Expedited External Review Process Implementation, *cont'd*

System Changes

Health Plans will modify our internal claims and appeals processes to administer the new requirements, and will update our claims and appeals guidelines and response letters.

IRO Contracts and External Review Coordination

Health Plans will contract with IROs on your plan's behalf. **Health Plans** will also coordinate the referral process to the applicable IRO, providing the required documentation and advising you of any additional material that a claimant may provide to the IRO.

Employer's actions

If **Health Plans** provides you with new information from the claimant via the IRO, you will need to respond within 1 business day to indicate whether the new evidence affects your decision to deny coverage.

If after a full review, the IRO reverses the denial, the plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Regulatory Update

Since the Affordable Care Act was enacted last March, the agencies responsible for implementing the law – the Departments of Labor (DOL), Health and Human Services (HHS) and Treasury (Treasury) – have issued numerous regulations and “sub-regulatory guidance”. The regulations and guidance describe the specific requirements for bringing plans into compliance with the law, and occasionally clarify or revise previously issued guidance. Some of the relevant recent updates are summarized below.

Rescissions

Rescissions of coverage are not permitted without providing the individual with at least 30 days advance written notice and the opportunity for an internal appeal. The definition of rescission included in the original regulations was clarified in October 2010 to exclude most routine retroactive terminations due to employment termination or divorce (for plans that do not cover ex-spouses). Please see page 2 for a more detailed explanation of the current distinction between retroactive terminations (which do not require prior notice and appeal) and rescissions.

Loss of Grandfather Status due to Carrier Change

Under the initial grandfathering regulations a health plan would automatically lose grandfathered (GF) status if it changed from one insurance carrier (or policy) to another after March 23, 2010 (without regard to whether the benefits or terms of the policy had changed in any significant way). On November 15, 2010, the implementing agencies amended the regulations to permit a change in insurance carriers on or after November 15, 2010, with no automatic loss of grandfathered status.

The new guidance allows plans to change insurance carriers, change contracts with an existing insurer, and change from fully-insured to self-funded or self-funded to fully-insured without losing GF status, as long as such changes are made effective on or after November 15, 2010. Plans that made such changes effective prior to November 15th will still be deemed to have lost GF status. As per the initial regulations, a change from one TPA to another has no effect on grandfather status.

However, keep in mind that all plans are subject to the loss of GF status based on certain cost-sharing or coverage changes as described in our August 20, 2010 Federal Health Care Reform Compliance Bulletin #2 on grandfathering provisions.

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Regulatory Update, *cont'd*

Automatic Enrollment

As described in our June 2, 2010, Federal Health Care Reform *Compliance Guide*, the Affordable Care Act requires employers with more than 200 full-time employees to automatically enroll new full-time employees in their group health plan and to continue enrollment of current employees. The statute indicated that the effective date would be established in implementing regulations.

In the latest set of FAQs issued by the implementing agencies on December 22, 2010 (FAQ V), the DOL indicated that employers are not required to comply with the automatic enrollment requirements until the regulations, which the DOL expects to complete by 2014, are issued. In the meantime, the DOL will be working with employers, workers and their families to solicit the views and current practices of a broad range of stakeholders regarding automatic enrollment.

Disclosure of Plan Benefits and Material Modifications

As described in our June 2, 2010 *Compliance Guide*, the Act requires plans to issue standardized benefit summaries (limited to 4 pages) and advance notice of plan changes. HHS is required to develop the content standards for benefit summaries and plans are required to distribute the new summaries by March 2012.

The Act also requires plans to provide 60 days advance notice of any material modification to a plan that was not included in the most recently provided summary of benefits. The Act did not specify whether it was referring to the required 4-page summary described above or any summary of benefits issued by the plan.

FAQ V looked at these notice requirements together and concluded that plans will not be required to comply with the 60-day prior notice of material modifications obligation until they are required to provide the standard benefit summaries described in the Act, (i.e., not before March 2012).

W-2 Reporting

As also described in our June 2nd *Compliance Guide*, the Act requires employers to report the value of employer-provided health coverage on each employee's W-2 beginning with the 2011 W-2 to be issued no later than January 31, 2012. On October 12, 2010, the IRS issued a notice announcing interim relief for employers stating that the form W-2 reporting is not mandatory for 2011 (although employers can voluntarily provide the reporting). This relief has been granted to provide employers with additional time to make necessary changes to their payroll systems and procedures. Employers are not subject to any penalties for failure to report the cost of employer-provided health coverage on W-2's for 2011. The Treasury and IRS plan to issue further guidance later this year. The IRS has emphasized, however, that the health care amounts to be reported on the form W-2 are not taxable income to the employee.

We will continue to issue updates to this series of *Compliance Bulletins* as any new legislation is enacted and as additional implementing regulations and guidance are issued.

In the meantime, please contact your **Health Plans** Account Manager if you have questions about how health care reform is currently affecting your plan(s).

This Bulletin is intended to provide a summary of our understanding of significant developments which may affect our clients' plans. It should not be construed as specific legal advice or legal opinion. The contents are for general informational purposes only and are not a substitute for the advice of legal counsel.