Proskauer

Healthcare Reform: Interim Final Regulations For Internal Claims and Appeals; External Review Processes For Group Health Plans and Health Insurance Coverage

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Group health plans and health insurance issuers (other than "grandfathered health plans" - Click here for client alert: Health Care Reform:Grandfathered Health Plan Interim Final Regulations Released) must begin complying with new internal claims and appeals and external review procedures for plan years commencing on or after September 23, 2010. The new procedures were issued under authority created by the Patient Protection and Affordable Care Act ("PPACA"), in the form of interim final regulations jointly issued July 22, 2010, by the Department of Treasury's Internal Revenue Service, the Department of Labor's Employee Benefits Security Administration ("EBSA"), and the Department of Health and Human Services ("HHS").[1] Unlike proposed regulations, interim final regulations are binding upon the effective date.[2] The agencies have requested comments regarding the new claims review procedures by September 21, 2010, but any changes to these procedures likely would be prospective only. Accordingly, plan sponsors likely need to update their claims review procedures before their next plan year begins.

PPACA requires group health plans and health insurance issuers offering group or individual health insurance coverage to implement an effective internal claims and appeals process for the determination of benefit claims, and also requires the establishment of state and federal external review processes to review benefit claim denials. The new claims procedure regulations set forth separate, although similar, rules for group health coverage and individual health insurance coverage for internal claims and appeals, and standards for state and federal external review processes. The rules applicable to the internal claims and appeals for group health plans, both insured and self-insured, are addressed in this alert.

EBSA has previously promulgated claims procedures designed to ensure "full and fair" review of claims under ERISA-covered plans by establishing procedures for the organized flow of information between plans and claimants. [3] For example, at the claimant's request, plans must provide all documents, records, and other information relied upon or generated during the consideration of a claim. The purpose of ERISA's internal review process is to reduce litigation and thereby reduce the cost of benefit claim disputes. Courts generally require claimants to exhaust internal administrative claims procedures as a prerequisite to seeking judicial review of their claims. The preamble to the new claims procedures regulations advises that EBSA is expected to update its existing claims procedures soon.

The interim final regulations impose six new obligations on group health plans and issuers in addition to the existing EBSA claims procedures.

1. *Broader Definition Of "Adverse Benefit Determination"*

Claims that may not otherwise have been subject to EBSA's claims procedure regulations will now be subject to both those procedures and the new claims procedures. The new regulations include a rescission of coverage within the definition of "adverse benefit determination," which broadens the claims that are subject to the claims procedures. Claim denials will be subject to the existing and new claims regulations if based upon a group health plan's determination that the individual is not eligible to participate in a plan, a benefit is not covered by the terms of a plan, the plan imposes a preexisting, source-of-injury, network, or other exclusion on otherwise covered benefits, or a benefit is experimental, investigative or not medically necessary or appropriate. [4] An adverse benefit determination includes both pre-service and post-service claims, and any rescission of coverage whether or not there is an immediate adverse effect on any particular benefit.

2. *Urgent Care Claims Must Be Decided As Soon As Possible, But No Later Than 24 Hours.*

Plans must notify claimants of benefit determinations (whether adverse or not) regarding urgent care claims as soon as possible, but no later than 24 hours following receipt, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered under the plan. This requirement is a significant change from the existing EBSA regulations requiring a response within 72 hours. When a plan requires submission of additional information to review the claim, the claimant must be afforded a reasonable amount of time, but no less than 48 hours, to provide the requested information.

3. Additional Criteria to Ensure A Claimant Receives A Full and Fair Review

In addition to complying with the existing EBSA claims procedures, group health plans must provide a claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim. This information must be provided sufficiently in advance to allow a claimant time to respond prior to the adverse benefit determination. Further, any new rationale for denying a claim on appeal or review must be disclosed to the claimant sufficiently in advance to allow the claimant time to respond prior to the adverse benefit determination on appeal or review.[5]

4. New Criteria To Avoid Conflicts of Interest By Decision Makers

The interim final regulations mandate additional precautions to ensure that claims and appeals are decided independently and impartially. Accordingly, plans cannot hire, promote, or terminate claims reviewers based on the likelihood that an individual will support a denial of benefits. For example, bonuses based on the number of claims denied are strictly forbidden. Similarly, a plan cannot contract with a medical expert based on the expert's reputation for outcomes in contested cases rather than the expert's professional qualifications.

5. New Notice Standards

Notices to individuals must be provided in a “culturally and linguistically appropriate manner.” Depending on the number of non-English speaking plan participants, written communications may be required in their native language. In addition to the existing notice standards under EBSA’s claims procedures, group health plans must provide:

(a) information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes;

(b) the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the plan’s standard, if any, that was used to deny the claim. For notices of final internal adverse benefit determinations, the description must include a discussion of the decision.

(c) a description of available internal appeals and external review processes, including how to initiate an appeal; and

(d) contact information for any applicable office of health insurance consumer assistance or ombudsman established under PPACA to assist individuals with the internal claims and appeals and external review processes.

6. Strict Adherence Required or Deemed Exhaustion of Internal Claims and Appeals Procedures

> If group health plans do not strictly adhere to all requirements of the internal claims and appeals process, claimants will be deemed to have exhausted the internal claims and review process regardless of whether the plan substantially complied with these requirements or any error committed is "de minimis." This is a different standard than the one applied under EBSA regulations. Accordingly, non-compliance with the new claims procedures could turn a claimant into a plaintiff empowered to seek external review or immediate judicial review of the benefit denial. Moreover, claims that incur a claims procedure failure are deemed denied on review without the exercise of discretion by an appropriate fiduciary. This could cause the plan to lose deference to its claim determination and lead a court to apply the de novo standard on judicial review.

The interim final regulations require that group health plans provide continued coverage pending the outcome of an internal appeal under the existing EBSA claims procedures, which generally provide that an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. However, the existing claims procedures allow a plan to notify a participant in advance that benefits will be limited and do not require additional formal notice that the approved course of treatment is coming to an end.[6]

The new claims procedures require group health plans to provide an effective external review process by Independent Review Organizations ("IROs"), by requiring plans to provide information to IROs regarding final adverse benefit determinations. The new claims procedures set forth standards for state external review processes and provide an outline of the federal external review process, the final details of which will be forthcoming. Due to preemption, most claims under self-insured ERISA-covered plans will be subject to the federal external review process. For plans providing health insurance coverage that is subject to a state external review process, these plans will not need to comply with the federal external review process if the state external review process meets the minimum consumer protection in the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act, upon which the federal external review process will be based. Decisions by IROs under the external review processes will be binding on the plan and claimant, except to the extent other remedies are available under state or federal law.

[1] Nearly identical regulations are published at 26 C.F.R. § 54.9815-2719T (IRS), 29 C.F.R. § 2590.715-2719 (EBSA), and 45 C.F.R. § 147.136 (HHS).

[2] The IRS issued temporary regulations, which are likewise binding on the effective date but will expire in three years if final regulations are not issued before then.

[3] 29 C.F.R. § 2560.503-1

[4] Rescissions of coverage must also comply with recently promulgated regulations restricting rescissions.[Click here for client alert: Health Care Reform: Interim Final Regulations Released for Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections]

[5] The regulation's preamble notes that these criteria are consistent with the EBSA's current interpretation of its existing claims procedures regulations, which interpretation has not been enforced by some courts.

[6] *See* 29 C.F.R. 2560.503-1(f)(2)(ii).

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