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LEGAL ALERT

Legal Alert: Health Care Reform Regulations - Internal Claims and Appeals and External Review Processes

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The Departments of Health and Human Services, Labor, and Treasury have published guidance regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets under the Patient Protection and Affordable Care Act (PPACA). The guidance includes Interim Final Rules published on July 23, 2010, model notices issued by the Department of Labor (DOL), and DOL Technical Release 2010-01 and Technical Release 2010-02 issued on August 23, 2010 and September 20, 2010, respectively. These requirements for internal claims and appeals and external review processes **do not** apply to grandfathered health plans.

Internal Claims and Appeals

Group Health Plans & Health Insurance Issuers Offering Group Health Insurance

Currently, all group health plans covered by the Employee Retirement Income Security Act (ERISA) must have a claims and appeals process for adverse benefit determinations that complies with existing DOL regulations.

The Interim Final Rule published on July 23, 2010 sets forth new requirements in addition to the existing DOL claims procedure regulations. Further, these requirements apply to both group health plans and health insurance issuers offering group health insurance coverage (i.e. self-funded and insured health plans). The requirements include rules related to:

1. Expanded definition of "adverse benefit determinations."

2. Notice of benefit determinations for urgent care claims must be provided within 24 hours of receipt of the claim.

3. Disclosures that ensure a full and fair review at the internal appeal stage, to include new or additional evidence or rationale considered, relied upon or generated by the plan or insurer in connection with the claim, and a reasonable opportunity for the claimant to respond.

4. Avoiding conflicts of interest.

5. Notices regarding claims and appeals must be provided in a culturally and linguistically appropriate manner (i.e. in the applicable non-English language depending on the percentage of non-English speaking participants).

6. Detailed notices of adverse benefit determinations and the availability of internal and external appeals must be provided.

7. Strict adherence to the internal claims and appeal process is required.

8. Coverage must be provided pending outcome of an internal appeal and simultaneous expedited external review may be allowed under certain circumstances.

Health Insurance Issuers Offering Individual Health Insurance Coverage

Health insurance issuers that offer individual health insurance coverage must generally comply with all the requirements for internal claims and appeals that apply to group health coverage. The Interim Regulations also set forth **three additional requirements** that apply to individual health insurance coverage:

9. Initial eligibility determinations for individual health insurance coverage are covered by the internal claims and appeals process.

10. Only one level of internal appeals is permitted. Thus, a claimant can seek either external review or judicial review after an adverse benefit determination is upheld in the first level of the internal appeals process.

11. Records of all internal claims and appeals processes must be maintained for at least six years.

Enforcement Grace Period

Under Technical Release 2010-02 published by the DOL, the federal agencies have indicated there will be no enforcement of items 2, 5, 6 and 7 above until July 1, 2011. Plans must comply with all other aspects of the Interim Final Rules and the existing DOL claims and appeals procedures. Also, the grace period only applies to plans that are working in good faith to implement items 2, 5, 6 and 7.

External Review Processes

State Process

Plans that are insured (individual and group coverage) or are non-ERISA self-funded plans (e.g. church or state and local government plans) must comply with their state external review process if the state process complies with the consumer protections under the NAIC Uniform Model Act. However, if the insured or non-ERISA self-funded plan is not subject to a state external review process or the state process does not meet the standards under the NAIC Uniform Model Act, such plans must comply with the federal external review process. Additionally, all ERISA-governed self-funded group health plans must comply with the federal external review process.

Federal Process

The DOL published Technical Release 2010-01 which outlines the procedures for the federal external review process. The federal external review process includes a "standard" external review and an "expedited" external review. The requirements for the **standard external review** include rules related to the following:

1. Requests for external review must be allowed under the plan and a claimant must file the request within 4 months after notice of an adverse determination or final internal adverse determination.

2. The preliminary review must be conducted by the plan within 5 days of receiving an external review request. The review is to determine if the claimant was covered at the time of service request or when service was provided, whether the internal appeal process was exhausted or not required to be exhausted, etc.

3. Referrals to (and the plan's selection of) an Independent Review Organization (IRO) for review of the claim. The IRO's decision is binding except for other remedies available under state or federal law.

4. The requirement to provide immediate coverage or payment (including immediately authorizing or paying benefits) if a notice reversing the adverse determination is received by the plan from the IRO.

The **expedited federal external review** process is triggered if there is an adverse benefit determination or a final internal adverse benefit determination that involves a claim for which the claimant's life, health or ability to regain maximum function would be seriously jeopardized if the normal internal appeals process or standard external review process were followed. An expedited review is also triggered if the final adverse benefit determination relates to an admission, availability of care, continued stay or service for which emergency services were received and there has been no discharge of the claimant.

The expedited federal external review requires that: (1) the plan must immediately conduct a preliminary review; (2) the IRO must receive all documents and information from the plan as soon as possible; and (3) the IRO must decide the external review no later than 72 hours after receiving the request for review.

Safe Harbor

There is also a safe harbor created for self-insured group health plans not subject to a state external review process. The safe harbor applies for plan years beginning on or after September 23, 2010, and until superseded by future guidance on the federal external review process. Under the safe harbor, the DOL and IRS will not take enforcement action against self-funded plans that comply with either of two specified interim compliance methods:

• First, self-funded plans may comply with the standard and expedited federal external review procedures outlined above; or

• If states decide to expand access to their external review process to include self-funded plans that are not otherwise subject to the state external review process, a self-funded plan may voluntarily comply with the state

process.

Complying With Notice Requirements

The Departments of Health and Human Services, Labor, and Treasury have provided model notices that can be used to satisfy the notice requirements under the Interim Regulations. These model notices are available at http://www.dol.gov/ebsa and http://www.hhs.gov/ociio/.

Why Should Grandfathered Plans Care?

Grandfathered health plans will not be required to comply with any of the new internal claims and appeals and external review processes described above. However, grandfathered plans under ERISA remain covered by existing DOL claims and appeals process regulations. As grandfathered plans review their plans for compliance with the PPACA, they should also review their plan documentation, processes, and notifications to ensure compliance with the existing DOL requirements.

If you have any questions regarding these issues, please contact one of the authors of this Alert, Isabella Lee, ilee@fordharrison.com, Penny Wofford, pwofford@fordharrison.com, or Daniel Sulton, dsulton@fordharrison.com, or the Ford & Harrison attorney with whom you usually work.

You may also visit the health care reform section of the Ford & Harrison website, http://www.fordharrison.com/shownews.aspx?Show=6690, for more helpful resources and tools on health care reform.