

Healthcare Reform: How to Interpret the New Internal & External Appeals Regulations

For Health Plans, Medical Management Organizations and TPAs

Introduction

Before hastily interpreting the new provisions of Section 2719 of the Patient Protection and Affordable Care Act and implementing new processes that may not be necessary, payer organizations should realize that most of them will generally be compliant with their existing internal appeals process and will not need to make any changes.

The requirement to implement a new federal external review process applies only to plans in the small number of states without existing regulations. Other plans can comply by voluntarily participating in their state external review processes or by implementing federal processes. The requirement to contract with at least three URAC-accredited independent review organizations (IROs) only applies to the external review process, and contracts for internal appeal processes require no change. It is important to keep all of this in mind when sifting through the voluminous legislation documentation.

The Patient Protection and Affordable Care Act

The recently enacted Patient Protection and Affordable Care Act (the Affordable Care Act) requires all non-grandfathered health plans to comply with the standards for both internal claims and appeals and external review processes. These requirements apply only to non-grandfathered health plans as of the first plan year beginning after September 23, 2010 (January 1, 2011, for calendar year plans). However, about half of employer plans will lose their grandfathered status on the first day of their coming plan year.

The interim final regulations jointly published by the Departments of Labor (DOL), Department of Health and Human Services (HHS), and the Treasury Department earlier this year provide the standards for processing internal claims and appeals, the basis for determining when plans and issuers must comply with applicable state external review processes or federal external review processes, and the minimum requirements that state external review processes must meet. The most recent DOL technical release addresses the federal external review processes, provides interim procedures for self-insured health plans, and models notices for both internal claims and appeals and external review processes.

Before hastily interpreting the new provisions of Section 2719 of the Patient Protection and Affordable Care Act and implementing new processes that may not be necessary, payer organizations should realize that most of them will generally be compliant with their existing internal appeals process and will not need to make any changes.

How Does the Act Affect Your Plan's Practices?

Internal Claims and Appeals

Group health plans and issuers that offer group or individual coverage are required to implement an effective internal claims and appeals process. As a starting point, group health plans must adopt the DOL's regulations that govern internal claims and appeals procedures in accordance with Section 503 of the Employee Retirement Income Security Act (ERISA). Plans and issuers must also modify their claims procedures to meet a number of additional requirements:

- ▶ **Expanded definition of adverse benefits determination.** Adverse determinations that are subject to these new claims and appeals processes include the denial of, the reduction or termination of, or the failure to provide coverage or make a payment for a benefit. The regulations also expand upon this definition by including any rescission of coverage, regardless of whether any particular benefits were denied.
- ▶ **Reduced timeframe for deciding urgent care claims.** The regulations reduce the timeframe for deciding urgent care claims and notifying claimants from no later than 72 hours to no later than 24 hours after the receipt of the claim by the plan.
- ▶ **Additional protections to ensure a full and fair review.** The plan must provide the claimant, at no cost, any new evidence that was considered, relied upon, or generated by the plan in connection with the claim. 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.** The regulations require that all claims and appeals must be decided in a manner that ensures the independence and impartiality of the person making the benefits determinations. Decisions regarding the hiring, compensation, termination, promotion, or similar matters of a claims adjudicator or medical expert cannot be based upon the likelihood that the individual will deny a claim.
- ▶ **Culturally and linguistically appropriate notices.** Notices to enrollees regarding benefit determinations must be provided in a culturally and linguistically appropriate manner. Notices must be provided in a non-English language, if the number of participants who are literate only in the same non-English language exceeds certain thresholds, which are adapted from the DOL's regulations regarding style and format for summary plan descriptions. Oral notices involving urgent care can be provided in English as long as the follow-up written notice is provided in the appropriate non-English language.
- ▶ **Additional content requirements for notices.** Notices of adverse benefit determinations must contain the date of service, the healthcare provider, the claim amount, the diagnosis code, the treatment code, and the meanings of the codes. The reasons for the adverse decision must also include the denial code and an explanation of the code. The notice must also include a discussion of any plan standard used in the determination, a discussion of the claim and appeal procedures, and the contact information for any applicable consumer assistance office.
- ▶ **Strict adherence to the claims procedures.** The 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 to pursue other applicable remedies (for example, legal action). "Substantially complying" with the rules or de minimus 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 (TPAs) are complying with the new rules and should determine whether their TPAs are or should be contractually liable for any related failures.
- ▶ **Continued coverage during an appeal.** Claimants must be provided continued coverage while waiting for an internal appeal decision. Plans and issuers must comply with the requirements of the DOL claims procedures regulations, which generally prohibit a plan or issuer from reducing or terminating an ongoing course of treatment without providing advance notice and an opportunity for advance review. In addition, individuals in urgent care situations and individuals receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process, under either a state external review process or the federal external review process.

How Does the Act Affect Your Plan's Practices?

External Review Processes

In addition to the internal claims and appeals procedures, non-grandfathered plans and issuers of non-grandfathered policies must adopt either a state external review process or the federal external review process. Most health insurance

issuers, insured plans, certain self-funded plans, and multiple employer welfare plan arrangements will be subject to state external review processes in those states that have such processes in place. However, HHS will determine whether a state external review process meets the minimum standards set forth by the consumer protections in the Uniform Health Carrier External Review Model Act of the National Association of Insurance Commissioners ("NAIC Model Act").

Alabama, Alaska, Mississippi, Nebraska, South Dakota, and Wyoming are the only states that did not have external review processes when the Act was enacted. At least two of these states are moving quickly to pass new rules that establish state external review processes. Plans that are not subject to their state's processes, plans in the states with no processes, and plans in states that do not meet the minimum standards of the NAIC Model Act after July 1, 2011, must comply with the federal external review process, which requires plans to contract with at least three URAC-accredited IROs to conduct external reviews, in order to ensure unbiased and independent decisions. Plans in states with external processes that do not apply directly to them (some state processes only apply to HMOs, for example) may choose to voluntarily participate in the state's process rather than the federal process, if the state expands coverage to these plan types.

A transition period will allow states the opportunity to amend their laws to meet the NAIC external review standards. If a state has not amended its laws to satisfy the minimum requirements by July 1, 2011, issuers and plans who were once subject to the state's insurance laws will have to comply with the federal process.

Federal External Review Process

The regulations provide that self-funded ERISA plans and plans and issuers in states without state external review processes that meet the minimum standards of the NAIC Model Act must comply with the federal external review process. Those plans in states with no external review process must comply with HHS' interim federal process, for which they have issued Technical Guidance.

The federal external review process will generally apply to all adverse benefit determinations, but adverse benefit determinations related to eligibility are not within the scope of the federal external review.

The agencies recently issued a joint notice that set forth interim safe harbor standards for complying with the federal external review process for self-insured group health plans and issuers. The safe harbor provides plans an extension until July 1, 2011, with respect to some of the standards in the interim regulations, including the standard regarding substantial compliance with the regulations. This safe harbor is described in the DOL Technical Release 2010-02 (released September 20, 2010).

Self-Funded Plans:

For plan years beginning on or after September 23, 2010, until future guidance is issued, self-funded plans will be considered to be in compliance with federal external review requirements if they either comply with the federal external review procedures set forth in Technical Release 2010-02 or voluntarily comply with a state's external review process, if the state expands access to its external review process to plans that are not subject to state law. The agencies intend to issue future guidance no later than July 1, 2011, to replace the interim federal external review process.

Issuers:

For plan years (and policy years in the individual market) beginning on or after September 23, 2010, until future guidance is issued, issuers in states without state external review processes that meet the minimum standards of the NAIC Model Act will be deemed to be in compliance with federal external review requirements if they comply with an interim compliance method to be determined by HHS. HHS will issue guidance as to which state external review laws satisfy the minimum standards of the NAIC Model Act. The agencies intend to issue future guidance no later than July 1, 2011, to replace the interim federal external review process.

For standard external reviews, self-funded group health plans must comply with the following requirements:

- ▶ Allow a claimant to file a request for an external review for up to four months after the date of the receipt of a notice of an adverse benefit determination.

- ▶ Within five business days of the receipt of the external review request, the plan must complete a preliminary review of the request to determine whether
 - ▶ The claimant was covered under the plan at the time the item or service was requested or provided
 - ▶ The adverse benefit determination does not relate to the claimant's failure to meet eligibility requirements
 - ▶ The claimant has exhausted the plan's internal appeals process unless the claimant is not required to exhaust the internal appeals process under the regulations
 - ▶ The claimant has provided all necessary information and forms to process an external review.
- ▶ Within one business day of completing the preliminary review, the plan must issue a written notification to the claimant. If the request is complete but not eligible for external review, the notice must include the reasons why the request is ineligible and contact information for the Employee Benefits Security Administration. If the request is incomplete, the notice must describe the information needed to make the request complete, and claimants must be allowed to perfect the request within the four-month filing period or within 48 hours of receipt of the notice, whichever is later.
- ▶ Assign an accredited IRO to conduct the external review. To ensure unbiased and independent decisions, plans must contract with at least three IROs and either rotate claims among them or use other independent, unbiased methods for selection, such as random selection. The contracts between the IRO and the plan must satisfy certain requirements.
- ▶ The IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.
- ▶ If the IRO reverses the plan's adverse benefit determination, the plan must immediately provide coverage or payment for the claim.

Self-funded health plans must also allow for expedited external reviews under certain circumstances. The process for an expedited external review mirrors the process for a standard external review, except that the plan must immediately determine if a request is eligible for external review and must provide all the necessary documents and information to the assigned IRO electronically, by telephone, by facsimile or any other available expeditious method.

Failure to Comply

If a plan or issuer fails to "strictly adhere" to the internal claims procedure requirements, a claimant who is deemed to have exhausted the internal claims and appeals procedures may initiate an external review and pursue any available remedies under the applicable law(s). Courts will review any such claims without giving deference to the plan or issuer.

In addition, group health plans that fail to comply with the requirements may be liable for excise taxes equal to \$100 for each day of noncompliance with respect to each individual to whom such failure relates.

Conclusions

These new internal claims and appeals procedures and external review procedures apply only to non-grandfathered group health plans and individual policy issuers. Employers who are considering design changes to their existing plans that would result in the loss of grandfathered status should consider the administrative issues and costs involved with complying with these new procedures.

Most health insurance issuers, insured plans, certain self-funded plans, and multiple employer welfare plan arrangements will be subject to state external review processes in those states that have such processes in place.

In the case of insured plans, the issuer has primary responsibility to comply with the regulations and the latest guidance. Plan sponsors should consider confirming that the issuer will comply with the new internal claims procedures and external review requirements.

In the case of self-funded plans, plan sponsors who are involved with claims administration, including those who outsource claims administration to a TPA but retain the authority to decide final internal appeals, will have to comply with the new requirements.

Keep in mind that most health insurance issuers, fully-insured plans, certain self-funded plans, and multiple employer welfare plan arrangements will generally be subject to existing internal appeals processes, and many will carry on under existing state external review processes.

HHS' new federal external review process applies only to those plans in the handful of states without existing regulations. Plans in states with external review programs that do not apply to them are required to contract with at least three URAC-accredited IROs to conduct external reviews. The contracts for these external reviews should be kept separate from those for internal reviews, since the federal external review process requirements do not affect other types of reviews.

About AllMed

Founded in 1995, AllMed is a URAC-accredited independent review organization (IRO) that services leading health insurance payers, third-party administrators, and claims and medical management organizations nationwide.

AllMed offers MedCert®, a first-level physician review solution for payer organizations that are considering outsourcing. MedCert is deployed as a service through AllMed's PeerPoint Medical Review Portal. All reviews are conducted by AllMed's team of in-house physicians, who are licensed, board-certified physicians in active practice. For more information on MedCert and AllMed's services for payer organizations, go to www.allmedmd.com.

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