



DATE: August 11, 2010
TO: Our Valued Client Partners & Friends
FROM: HIB Account Team
RE: **LEGISLATIVE UPDATE 2010-15**
Health Care Reform: New Claims Appeals Rules

We are pleased to bring you our **Legislative Update 2010-15: Health Care Reform: New Claims Appeals Rules**. This update provides detailed discussion on the rules for claims appeals. Your HIB Account Team will work with you to help you understand these regulations and assist you with compliance.

As always, please feel free to contact your HIB Account Team for assistance.

Health Care Reform: New Claims Appeals Rules

On July 22, 2010, the Departments of Labor, Health and Human Services, and Treasury (The Agencies) released [Interim Final Rules](#) (New Rules), applicable to non-grandfathered plans, expanding the mandatory health care claims appeals rules for both insured and self-insured plans. These New Rules generally take effect for plan years beginning on or after September 23, 2010.

IN BRIEF

These New Rules expand the Department of Labor (DOL) claims appeals rules first issued in 2000, and requires an external appeals process. It's worth noting that most, but not all, states have an external appeals process for insured plans, and prior to these New Rules, self-funded plans had no such requirement. The Agencies rely heavily on a [model rule](#) developed by the National Association of Insurance Commissioners (NAIC Model) as the backbone of the New Rules.

THE NAIC MODEL

1. **The NAIC Model Rule.** Although not a law itself, the NAIC Model is one of many models drafted to assist states in developing uniform insurance rules which ease the burden on insurance companies attempting to comply with laws in the states where they do business.
2. **The Standards.** With respect to this analysis, the NAIC contains the following key rules mostly regarding external reviews:
 - i **External review of plan decisions** to deny coverage for care based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
 - i **Clear information** for consumers about their right to both internal and external appeals - both in the standard plan materials, and at the time the company denies a claim.
 - i **Expedited access** to External Review in some cases - including emergency situations, or cases where their health plan did not follow the rules in the internal appeal.
 - i **Health plans must pay the cost of the external appeal** under state law, and states may not require consumers to pay more than a nominal fee.
 - i **Review by an independent body** assigned by the state. The state must also ensure that the reviewers meet certain standards, keep written records, and are not affected by conflicts of interest.
 - i **Emergency processes for urgent claims** and a process for experimental or investigational treatment.



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- i **Final decisions must be binding:** If the consumer wins, the health plan is expected to pay for the benefit that was previously denied. If the consumer loses, he/she will continue to have access to judicial review.
- 3. **Applicability.** For purposes of internal review procedures, insurers must follow the rules (both NAIC Model and non-NAIC rules) specified in the Interim Final Rules. The external review process will replace the voluntary second review process found in many plans today.

The New Rules requires that the state external review process provide, at a minimum, the consumer protections contained in the NAIC model as of July 23, 2010 (the date the Agencies published the Interim Final Rule on the subject). Insurers doing business in a state that meets these standards must provide external reviews using the state external review process. Similarly, self-funded plans *not* subject to ERISA must allow for external review using the state review process if it meets the NAIC standards.
- 4. **Defective State Rules.** Insurers and self-funded plans (not subject to ERISA) in states where the external review process does not meet the NAIC standards as of July 1, 2011 must comply with a federal external review process for adverse claims determinations made as of the first day of the plan year beginning on or after July 1, 2011. Agencies also may deem existing state external review processes or insurer or self-funded health plan external processes as compliant as long as they were in effect on March 23, 2010.

DISCUSSION

- 1. **Effective Date.** Both the internal review and external review processes will apply beginning with the first day of the plan year beginning on or after September 23, 2010 and are applicable to *non-grandfathered plans only*. For states without a current insured plan external review mechanism, plans will be given until July 1, 2011 to enact the necessary legislation to create such a mechanism, as discussed above. Health Care Reform (HCR) law allocates \$31 million in grants available to states for instituting or upgrading their external review process. These new rules apply to adverse determinations made on or after the first day of the plan year of the non-grandfathered plan occurring on or after September 23, 2010.
- 2. **New Definition: Adverse Benefit Determination.** In brief, a failure by the plan to pay the total amount of expenses submitted in whole or in part or a rescission of coverage constitute an adverse benefit determination. Adverse benefit determinations, which become eligible for internal review and appeal, include the following:
 - i A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:
 - o A determination of an individual's eligibility to participate in a plan or health insurance coverage;
 - o A determination that a benefit is not a covered benefit;
 - o The imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or,
 - o A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

As you may recall, HCR prohibits retroactive policy rescissions (other than for non-payment of premiums) except in the case of fraud or an intentional misrepresentation of fact.



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- 3. Urgent Claims Rule Modified.** This Interim Final Rule modifies the existing notice requirements contained in the current DOL claims and appeals procedures regulations, in the case of a claim involving urgent care, by accelerating adjudication to occur no later than 24 hours after receipt of a claim containing sufficient information to allow for its adjudication. This replaces the old DOL standard of 72 hours. According to the Rule's preamble, the Agencies agreed to change this rule in light of today's advanced electronic communications capability.
- 4. Clarification of Rights under Full and Fair Review Requirement.** Since the issuance of the original DOL rule, the DOL has asserted that claimants have a right to review any "new or additional evidence" the reviewer may consider or rely upon in its decision on the claim. There are numerous court holdings to the contrary (i.e. that the claimant has no "right" per se to review and respond to this new evidence (e.g. additional doctor's reports, experts' written statements, etc.). The new Rule requires the reviewer to provide the claimant with any new evidence as soon as possible and sufficiently in advance of the reviewer's statutory date for a decision (usually 60 days), to allow time for the claimant to respond to or refute the new evidence. If the reviewer intends to base an adverse ruling on this new evidence, he/she must provide the rationale to the claimant in advance and must allow the claimant reasonable time to respond prior to issuance of the denial.
- 5. Conflicts of Interest.** The plan or issuer must ensure that all claims are adjudicated in an impartial manner. In the event the plan or issuer hires an expert, for example, the decision about whom to hire must not be based on the likelihood the expert will support the denial of benefits. Additionally, a plan or issuer must not pay bonuses to the claims examiners based on the number of claims denials he or she generates. For purposes of the external claims appeals special rules, discussed below, the element of impartiality of the independent reviewer is a key component.
- 6. Claims Related Notices.** The new Rule requires that plans and issuers must issue all claims-related notices to enrollees in a culturally and linguistically appropriate manner. In addition to the requirement that a notice be written in a manner that is easily understood by plan participants, it also must be in the appropriate language when 25% or more of all plan participants are literate in that language, for plans with less than 100 participants at the beginning of the plan year, and for plans with more than 100 participants, the lesser of 500 participants or 10% of all plan participants being literate in a non-English language. The notice in English must contain a prominently placed statement in the foreign language indicating the availability of the notice in that language.

As required under the DOL current regulations, the notices also must contain enough information to identify the claim involved, date of services, provider, claim amount, as well as the diagnosis codes with their meanings. Under the new Rule, the notice also must contain a description of the reviewer's standard, if any, used in denying the claim, such as medical necessity. Notices regarding appeals must include a narrative discussion of that decision and a description of the available internal and external appeals processes and how to access them. As required by most state laws, the notice must also provide the contact information for any applicable reviewing agency, including the new state-level consumer assistance agency established under HCR. We understand that the Agencies will provide model notices shortly.
- 7. Flawed Reviews and External Review Options.** In the event that a plan or issuer fails to adhere to all the requirements of the rules for claims appeals, regardless of how minimal, a claimant may seek an External Review and pursue judicial review (i.e. ERISA Section 502(a)). The Rule also requires that plans/issuers continue to provide coverage during the pendency of such reviews.



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8. **External Reviews Generally.** The HCR law requires that plans and issuers must comply either with a state External Review process or the federal review process. Self-funded plans subject to the Employee Retirement Income Security Act (ERISA) must use the federal rules. Otherwise, the Interim Final Rule provides the basis for determining which review process will apply based on an extensive set of criteria related to consumer protections. In summary, a claimant whose appeal has been denied, has the right to have an independent reviewer (i.e. someone not employed by the health plan). Although the National Association of Insurance Commissioners has adopted a model External Review process, not all states have adopted it. The Interim Final Rule gives states until July 1, 2011 to adopt the NAIC model.
9. **State External Review Standards.** In addition to containing the NAIC consumer protections, the state external review process must also meet the following standards:
 - i The review must apply to adverse determinations involving:
 - o Medical necessity
 - o Appropriateness
 - o Health care setting
 - o Level of care
 - o Effectiveness of a covered benefit
 - i The state must provide effective written notice to claimants on their rights in connection with the external review process (using the same language requirements as applicable under the internal review process).
 - i Suspension of the rules on exhaustion of remedies under certain conditions.
 - i The issuer or the self-funded health plan must pay the cost of the independent review organization (IRO) which will conduct the external review; however, the state may charge a nominal fee to the claimant (not to exceed \$25.00) which must be refunded if the original decision is reversed. The state may waive the fee if it is a financial hardship.
 - i The state may not impose a minimum threshold for claims under review.
 - i Claimants must have four months from receipt of the adverse determination to file for the external review.
 - i The state must assure the independence of the IRO assigned to review the adverse determination. The Interim Final Rule prohibits the issuer, the health plan, or the individual from picking the organization to be used. The IRO also must not have a conflict of interest.
 - i The state must maintain a list of IROs based on the nature of the claim or service, and they must be accredited by a nationally recognized private accrediting organization.
 - i The state must allow a claimant five (5) business days to provide additional information in writing to the IRO; the state must notify the issuer or the self-funded plan accordingly within 24 hours of receipt of the additional information.



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- i The decision must be binding on all parties, except to the extent that there are judicial remedies.
- i The IRO must provide written notice to the issuer or to the self-funded plan, as applicable, within 45 days of the claimant's request for review.
- i The process also must provide for expedited reviews (in the case of emergency services, etc.) within 72 hours of receipt of the request.
- i The states must require issuers or, if applicable, the self-funded plans to include a written description of the external review process in or attached to the relevant summary plan description, certificate, insurance policy, or evidence of coverage documents provided to plan participants.

10. The Federal External Review Process. Insured and self-funded ERISA plans not subject to the state external review process either because the state's process is not compliant or the state has no jurisdiction (in case of self-funded ERISA plans), must comply with the federal external review process. The Agencies will provide additional guidance on the federal process; however, in the meantime, the Interim Final Rule states that the federal process will be similar to the NAIC model.

WHAT YOU SHOULD DO

1. For non-grandfathered insured plans, plan sponsors need only to confirm that the insurer will meet the requirements of the Interim Final Rule as of the first day of the insured plan's plan year. If the plan renewal date and the plan year start date are different, determine the insurer's stance of when the rule will apply.
2. For non-grandfathered self-funded plans, or for public agency or church plans, the plan sponsor must bear the major burdens of implementation of the rule, especially with regard to the notice requirements. The plan sponsor must look for and rely upon additional guidance, which are expected shortly.
3. Employers with a large (25% or more) non-English speaking population must assure that the insurer or, in the case of the self-funded plan, the plan sponsor must provide notices in the second language, in the format specified in the New Rules.

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