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CLAIMS AND APPEALS PROCEDURES: NEW INTERNAL AND EXTERNAL REVIEW REQUIREMENTS

The Patient Protection and Affordable Care Act, as amended ("PPACA"), requires group health plans and health insurance issuers to provide both an internal claims and appeals process and an external review process. Because this new requirement (the "Appeal and Review Mandate") applies to both group and individual insured coverage as well as to self-insured plans, the same process for administratively contesting a denied claim for health benefits will be available to all covered individuals, regardless of state of residence or source of coverage. The Appeal and Review Mandate is effective for plan years beginning on or after September 23, 2010 (January 1, 2011, for calendar-year plans), and does not apply to grandfathered plans.[1]

On July 22, 2010, the Departments of Labor, Treasury, and Health and Human Services issued interim final regulations regarding the Appeal and Review Mandate (the "Regulations"). Further guidance regarding the federal external review process (which will apply for most self-insured coverage) will be issued at a later date. In this *Commentary*, we discuss the impact of the Appeal and Review Mandate on employer-sponsored group health plans.[2]

In complying with the Appeal and Review Mandate, group health plans will need to amend their plans, summary plan descriptions, and other communications and work with their claims administrators to update relevant procedures and claims response notices.

1 Generally, grandfathered plans are plans in existence on March 23, 2010, that have not made significant changes in cost or coverage. For a more detailed discussion about grandfathered plans, see the Jones Day *Commentary* entitled "The More Things Change, the More They Stay the Same: Is It Worth Maintaining Grandfathered Status Under the New Health Care Law?"(June 2010), published on the Jones Day web site.

2 Except as expressly noted, the discussion in this *Commentary* about group health plans applies equally to health insurance policies issued to such plans. Note also that these new rules apply only to health plans. They do not apply to claims under other plans, such as life insurance or disability benefit plans.

CURRENT CLAIMS AND APPEALS REQUIREMENTS

Under the law prior to PPACA, group health plans subject to ERISA were required to satisfy the claims procedure requirements under ERISA section 503, and insured group health plans also had to satisfy relevant state insurance law requirements regarding claims and appeals. These currently existing requirements still apply, with certain modifications described below.

Section 503 and the regulations thereunder require plans subject to ERISA to maintain reasonable claims procedures and to allow for a full and fair review of denied claims. The regulations under ERISA section 503 set forth numerous requirements regarding claims and appeals, including the following:

- A description of the process must be included in the summary plan description;
- No fee to file or other requirement may be imposed that unduly inhibits claimants;
- In determining claims, the provisions of the plan must be consistently applied;
- The process must comply with certain time periods in responding to both claims and appeals, with the time periods varying depending on the type of claim (for example, urgent care claims must be responded to on an expedited basis);
- Notices of adverse determinations must include specific items regarding the determination and a description of the review process;
- Appeals must be determined by a fiduciary who is not the person who made the decision being reviewed (or his or her subordinate), and no deference may be given to the earlier decision; and
- The process may not require more than two levels of internal appeals before the claimant may file an action in court, and the claimant's right to sue cannot be eliminated (for example, the plan cannot require binding arbitration).

If a plan fails to establish or follow procedures consistent with these requirements, the claimant will be deemed to have exhausted the administrative remedies and may bring a civil action in court. In addition, the court may decide to not give deference in such action to any decision made by the claims administrator.

Insured group health plans, regardless of whether or not they are subject to ERISA, are subject to state insurance laws regarding claims and appeals. These laws vary among the 50 states. In many states, final appeals decisions for certain insured coverage are also subject to external review.

CHANGES TO INTERNAL CLAIMS AND APPEALS PROCESS

The Appeal and Review Mandate requires all group health plans (and all individual health coverage) to comply with the ERISA claims and appeals process, subject to certain modifications described below. This means the ERISA claims and appeals requirements will be extended to plans, such as church and governmental plans, to which these requirements did not previously apply. Because PPACA does not apply to stand-alone dental or vision plans or to other non-health-related welfare plans, this extension of the ERISA claims and appeals requirements will not apply to all plans sponsored by such entities, just health plans governed by PPACA.

Definition of "Adverse Benefit Determination." Under PPACA, the Appeal and Review Mandate applies to any adverse benefit determination. An "adverse benefit determination" under the ERISA claims and appeals process is a claims determination that may be appealed. The Regulations make it clear that an adverse benefit determination includes any cancellation or discontinuance of coverage that has a retroactive effect (a "rescission"), whether or not there is an adverse effect on any particular benefit in connection with the rescission.

Notification of Urgent Care Benefit Determinations. The time period for providing notification in the case of an urgent care claim continues to be "as soon as possible, taking into account the medical exigencies," but the maximum time period is reduced from 72 hours to 24 hours after receipt of the claim. This reduction in time appears to apply only with respect to notice following the initial claim and not

to notice following an appeal. The current rules regarding extending the time period if the claimant fails to provide sufficient information continue to apply.

Full and Fair Review. A group health plan must provide a claimant with any new or additional evidence considered, relied upon, or generated by or at the direction of the plan in connection with an appeal. In addition, before a group health plan can deny an appeal based on a new or additional rationale that was used in responding to the claim, the claimant must be provided with information about the new or additional rationale and the evidence supporting it. The new or additional rationale and/or evidence must be provided free of charge, as soon as possible, and sufficiently in advance of the time limit for the plan's responding to the appeal to allow the claimant a reasonable opportunity to respond prior to that date. There is no bright-line rule about what is "sufficiently in advance" for these purposes.

Effectively, these new requirements mean that group health plans must review appeals immediately upon receipt to allow for potential interim "mini appeals" prior to the deadline for responding to the appeal. In addition, plans that currently allow for two levels of appeal might consider reducing that to one to maximize the time allowed for the above process to take place.

Avoiding Conflicts of Interest. For persons charged with hearing a claim for benefits, neither hiring, compensation, termination, promotion, nor similar matters can be based on their supporting (or the likelihood of their supporting) the denial of benefits. Therefore, a group health plan (or third-party administrator handling claims) may not, for example, base the compensation or bonuses of a claims reviewer on the percentage of claims denied or on the denial of a particular claim. Likewise, the selection of an individual for such position may not be based on the individual's propensity to deny claims.

Deemed Exhaustion of Internal Claims and Appeals Process. Failure to *strictly* adhere to *all* the internal claims and appeals requirements, both as currently existing under ERISA and as modified under the Appeal and Review Mandate, will mean that the claimant is deemed to have exhausted the internal claims and appeals process. The claimant may then immediately initiate an external review (as described below) or litigation. If the claimant chooses to initiate litigation under ERISA section 502(a), the claim or appeal is deemed denied on review without the exercise of fiduciary discretion, meaning that the court will review the case *de novo* and not give deference to any decision that was made by the claims administrator. The threshold for strict adherence to all requirements is a high bar, and the Regulations specifically indicate that substantial compliance or *de minimis* errors will not prevent the internal process from being deemed exhausted.

Continued Coverage Pending Appeal. A group health plan is required to provide continued coverage pending the outcome of an appeal. The Regulations, however, only reference the already existing requirement to continue coverage during the pendency of a concurrent care review of an ongoing course of treatment. Presumably, they do not intend for continued coverage to be provided during the pendency of an appeal regarding rescission of coverage, given that the new regulations concerning rescission specifically provide that only 30 days' advance written notice of the rescission must be given "regardless of any contestability period that may otherwise apply."[3]

CLAIMS NOTICES AND CULTURALLY AND LINGUISTICALLY APPROPRIATE COMMUNICATION

In addition to the existing ERISA requirements for notices of adverse benefit determinations, the Regulations require that the notice must also meet certain additional requirements. All notices in connection with claims, appeals, and external reviews must accommodate non-English speakers if a substantial number of participants are literate *only* in the same non-English language.

Additional Items Required in Notices of Adverse Benefit Determination. Adverse benefit determination notices must include:

3 ERISA Reg. § 2590.715-2712(a)(1); Treas. Reg. § 54.9815-2712T(a)(1); HHS Reg. § 147.128(a)(1).

- The date of service, the health-care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and any other information necessary to sufficiently identify the claim involved;
- The reason(s) for the adverse determination, including the denial code and its corresponding meaning and a description of any plan standard used in denying the claim;
- A discussion of the decision if the adverse determination is in response to the final level of internal appeal;
- A description of the available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- The availability of and contact information for any office of health insurance consumer assistance or other ombudsman who can assist individuals with internal claims and appeals and external review processes.

Culturally and Linguistically Appropriate Communications. A group health plan must provide notices related to claims, appeals, and external reviews, upon request, in a non-English language if either (a) the plan covers fewer than 100 participants at the beginning of the plan year and 25 percent or more of all plan participants are literate *only* in the same non-English language; or (b) the plan covers 100 or more participants at the beginning of the plan year and the lesser of (i) 500 or more participants or (ii) 10 percent or more of all participants are literate *only* in the same non-English language.

If either of these thresholds is met, all English versions of these notices must include a prominent statement in the applicable non-English language offering to provide the notice in the non-English language. If the non-English version of a notice is requested by a claimant, all subsequent notices to the claimant must be in the non-English language. If the plan maintains a customer assistance process, including a telephone hotline, that answers questions or provides assistance with filing claims and appeals, such assistance must also be provided in the non-English language.

EXTERNAL REVIEW PROCESS

Group health plans must also provide for an external review. The external review will be governed by either a state process or a federal process, depending on the type of coverage and whether or not a state process meeting certain minimum standards is available. The default external review process is the state process, as long as it meets the minimum standards and applies to and is binding on the plan (or issuer if the coverage is insured).

It is likely that all fully insured group health plan options issued in a state with a compliant external review process will be subject to the state process. However, if the state process does not meet the minimum standards or is not binding on the type of coverage, the insured health plan option must comply with the federal process.

Whether self-insured group health plan options must comply with a state process will depend in part on whether the principles of ERISA preemption apply. A state process is not binding on a self-insured plan where the state process would be preempted by ERISA.[4] Therefore, a compliant state process also may apply with respect to self-insured church plans and non-federal government plans, which are not subject to ERISA, and multiple employer welfare arrangements (MEWAs), which are subject to state law and ERISA. Self-insured health plans for which a state process is not binding because of ERISA preemption must comply with a federal process. Likewise, if the state process does not meet the minimum standards or does not apply by its terms to the self-insured coverage, the self-insured health plan must comply with the federal process.

State External Review Processes. In order for a state external review process to be used as the external review to comply with the Appeal and Review Mandate, it must meet certain minimum requirements set forth in the Regulations. These requirements are derived from the National Association of Insurance Commissioners Uniform Model Act and, according to the Preamble to the Regulations, constitute the minimum consumer protections that should be included in an external review process.

4 *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002).

The Department of Health and Human Services is charged with reviewing state processes and determining whether they meet these requirements. While a majority of states currently provide for external review processes with respect to health insurance coverage in their state, it appears that most of those processes will have to be revised or expanded in order to meet these minimum requirements. Because of this, the Regulations provide a transition period for existing state processes. Under this transition period, existing state processes are deemed to meet the requirements for plan years beginning before July 1, 2011. State processes that do not currently meet the minimum requirements will need to be revised by July 1, 2011, to constitute an effective external review process for purposes of the Appeal and Review Mandate on or after such date. The federal process will apply for states that do not currently have a review process until such time as a process that meets the requirements is implemented in those states. It is not clear how this transition period impacts claims that have been appealed to an external review process prior to July 1, 2011, but are still pending after the end of the transition period.

The minimum requirements for state external review processes include 16 separate items. Of particular note:

- The external review process applies to adverse benefit determinations concerning medical necessity, appropriateness, health-care setting, level of care, and effectiveness of a covered benefit.
- A nominal filing fee of no more than $25 may be charged to the claimant, with an annual maximum of $75 for any claimant within a single plan year. This fee must be refunded to the claimant if the claimant prevails in the external review. The fee must be waived if payment would impose an undue financial hardship.
- The plan (or issuer for insured coverage) must pay the cost of the independent reviewing organization ("IRO") for conducting the external review.
- The claimant must have at least four months to request an external review after the completion of the internal review, and there may be no minimum dollar threshold to be entitled to such review.
- IROs may not be selected by the plan, issuer, or claimant and must be assigned by the state or an independent entity on a random basis or by another method that ensures the independence and impartiality of the assignment process.
- IROs must be accredited by a nationally recognized private accrediting organization and may not own or control, or be owned or controlled by, a health insurance issuer, a group health plan, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health-care providers. In addition, the IRO and the clinical reviewer may not have a material professional, familial, or financial conflict of interest related to a particular review.
- The external review decision is binding on the plan (and issuer) but is binding on the claimant only to the extent that other remedies are not available under state or federal law, meaning that, in the context of an ERISA-regulated plan, an external review decision adverse to the claimant will not be binding and the claimant can still sue under ERISA section 502(a)(1)(B).

Federal External Review Process. The Regulations provide that the standards for the federal process will be set forth in later guidance. These standards will be similar to the process set forth in the National Association of Insurance Commissioners Uniform Model Act and will likely include the minimum requirements applied to the state process. The federal process will apply to any adverse benefit determination, *except* that a denial, reduction, termination, or failure to pay a claim based on the failure to meet an eligibility requirement will not be subject to the federal external review process.

CONCLUSION

The requirements of the Appeal and Review Mandate affect all non-grandfathered plans. Plan sponsors of these plans will need to ensure that their plan documents, summary plan descriptions, and other employee communication materials are properly revised and that relevant procedures and claims response notices are updated to comply with the Appeal and Review Mandate.

This is one in a series of *Commentaries* Jones Day intends to provide to our clients and friends on the provisions of PPACA. We will provide additional guidance on how the provisions of PPACA, and the developing regulatory framework, affect employer-sponsored health plans and their sponsoring employers as developments occur.

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