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EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION UPDATE

Thompson Hine's employee benefits lawyers understand the rising costs, increasing scrutiny and changing legal landscape facing employers who provide group health plan benefits to employees. We are working closely with our clients to help design, implement and administer health plans in this challenging environment. The breadth and depth of our experience allows us to identify best practices as they emerge and provide responsive, legally compliant and cost-effective solutions. For more information on ensuring that the design of your group health plan, employee communications and plan documentation comply with the Reform Legislation, please contact any member of our Employee Benefits & Executive Compensation practice group.

Health Care Reform: Claims and Appeals Procedures

This bulletin discusses certain provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, signed into law by President Obama on March 23 and 30, 2010, respectively (referred to collectively in this bulletin as the "Reform Legislation"), Interim Final Regulations regarding claims and appeals procedures and Technical Release 2010-01 regarding external reviews. This bulletin is the fourth in a series that will examine the impact of the Reform Legislation and implementing guidance on employer-sponsored group health plans.

Group health plans that are required to comply with the market reform provisions of the Reform Legislation and that do not have grandfathered plan status (see our prior bulletin for more information about grandfathered plan status) will be required to comply with enhanced claims and appeals procedure requirements. Any deviation from these procedures, no matter how small, will have significant consequences.

Plan sponsors who are considering forfeiting, or who have already decided to forfeit, grandfathered status should carefully review the new requirements and discuss them with their claims administrators. This bulletin explains the new requirements for internal claims and appeals procedures, explains the requirement to offer an external review, discusses the consequences for failure to comply and recommends actions for plan sponsors who may be subject to these requirements.

ENHANCED INTERNAL CLAIMS AND APPEALS PROCEDURE REQUIREMENTS

Prior to the effective date of the Reform Legislation, group health plans subject to ERISA are required to conduct claims and appeals in accordance with regulations issued by the Department of Labor (DOL). Effective for plan years beginning on or after September 23, 2010, non-grandfathered group health plans will also be required to comply with the following new requirements:



Treatment of a Rescission as an “Adverse Benefit Determination.” The regulations expand the current definition of “adverse benefit determination” to include a rescission (*i.e.*, the retroactive denial, reduction or termination of coverage). Group health plans will therefore be required to issue denial notices and permit appeals in the case of a rescission, even where there has been no claim or denial of payment.

Comment: The Reform Legislation prohibits rescissions except in the case of fraud or intentional misrepresentation and requires that 30 days’ advance notice be given before a plan permissibly rescinds coverage. As a result, any permitted rescission will need to be preceded by a denial notice explaining the evidence supporting a charge of fraud or intentional misrepresentation. A retroactive coverage termination due to nonpayment of premiums is not considered a rescission and therefore will not require an advance denial notice.

Shortened Response Time for Urgent Care Claims. Group health plans must respond to a claim involving urgent care within 24 hours. Under the current DOL regulations, plans have 72 hours to respond.

Notification of New Evidence or Rationales. Group health plans must automatically provide a claimant, free of charge, with any new or additional evidence or rationale considered, relied on or generated in connection with an appeal. The plan must provide the new evidence or rationale as soon as possible and sufficiently in advance of the adverse determination so that the claimant has time to respond before the determination is finalized.

Avoiding Conflicts of Interest. The claims or appeals adjudicator must be independent from and impartial to the group health plan. Decisions on hiring, termination, compensation, promotion or bonuses must not be based on the number of denials or the likelihood an adjudicator will uphold a benefit denial.

Inclusion of Additional Information in Denial Notices. In addition to the content currently required in denial notices, such notices must include:

- Information sufficient to identify the claim involved, including the date of service, health care provider, claim amount and the diagnoses, treatment and denial codes along with their corresponding meanings;
- A description of any standard used to determine the denial and, in the case of a final appeal determination, a discussion of the decision;
- A description of the available internal and external appeal processes, including information on how to initiate an appeal; and
- Contact information for any applicable office of health insurance consumer assistance.



*Comment: The DOL has published a model notice for **initial denials** and a model notice for **final denials**. Plans that use these models should ensure that the language inserted under the heading “Explanation of Basis for Determination” includes all of the elements required under the current DOL regulations, including the plan provisions on which the determination is based.*

Comment: Many claims administrators use explanations of benefits (EOBs) as their denial notices. EOBs will therefore need to be revised to include the newly required information.

Providing Denial Notices in Non-English Languages. Certain claims and appeals information must be provided in a non-English language in the following cases:

- *For plans covering fewer than 100 participants at the beginning of a plan year: At least 25 percent of all plan participants are literate only in the same non-English language.*
- *For plans covering 100 or more participants at the beginning of a plan year: At least 500 or 10 percent of all plan participants (whichever is less) are literate only in the same non-English language.*

In these cases, the group health plan must provide denial notices in the non-English language upon request. In addition, English denial notices must include a prominent statement, in the non-English language, informing participants that they may request notices in the non-English language. Once a claimant requests a non-English notice, all subsequent notices must be provided in the non-English language.

Also in these cases, any customer assistance process (such as a telephone hotline) offered by the plan or insurer must provide assistance in the non-English language.

Providing Coverage Pending the Outcome of an Appeal. A group health plan must provide continued coverage pending the outcome of an appeal.

Comment: The preamble to the Interim Final Regulations states that plans must comply with the current DOL regulations regarding concurrent care claims (i.e., a plan may not reduce or terminate an ongoing course of treatment without advance notice and opportunity for review). It is not clear whether or how this requirement would be applied to other types of claims.

EXTERNAL REVIEWS

In addition to ensuring that the internal claims and appeals process complies with the Reform Legislation, non-grandfathered plans must offer participants the opportunity for an independent external review. A non-grandfathered group health plan must comply with any state external review procedures that apply to the plan if the state procedures meet certain minimum requirements. Otherwise, the plan must comply with federal external review procedures.



Comment: For plan years beginning before July 1, 2011, insured plans can comply with any applicable state process. The Department of Health and Human Services (HHS) is working with the states to bring their processes into compliance with the Reform Legislation's minimum requirements by July 1, 2011. HHS also plans to issue a safe harbor procedure for insured plans. Note that the insurer of an insured plan has the primary responsibility for complying with the claims and appeals requirements.

The DOL has provided a temporary safe harbor for self-insured plans. A non-grandfathered self-insured group health plan can comply with the Reform Legislation's requirements on external reviews if the plan complies either with the federal procedure described in the DOL's safe harbor or the provisions of a state external review process that would be applicable to the plan if the plan was an insured plan.

In order to comply with the DOL's safe harbor, a group health plan must take the following steps:

Permit Timely Requests for External Review. Plans must permit an external review if a claimant submits a request within four months after the claimant receives a claim or appeal denial notice.

Comment: In most cases, a claimant cannot request an external review until the claimant has exhausted the internal claims and appeals process. However, if the plan does not strictly comply with the Reform Legislation's requirements, a claimant can deem the internal process exhausted and request an external review. In addition, a claimant can request an external review in urgent care situations where exhaustion of the plan's process could seriously jeopardize the claimant's life, health, or ability to regain maximum function.

Conduct an Initial Review. Once a claimant has requested an external review, a plan must review the request within five days and determine:

- Whether the claimant was covered under the plan at the time the service was requested or provided;
- Whether the denial relates to the claimant's failure to meet the plan's eligibility criteria;
- Whether the claimant has exhausted the internal appeal process (or is not required to do so); and
- Whether the claimant has provided all of the information and forms necessary to process the external review.

Within one day following completion of this initial review, the plan must notify the claimant in writing regarding his or her eligibility for external review. If the request was not complete, the claimant may submit the additional necessary forms or information within the four-month filing period or the 48-hour period after the claimant receives this notification (whichever is later).



Contract with Independent Review Organizations. A plan must contract with at least three independent review organizations (IROs) that are accredited by **URAC** or a similar nationally recognized accrediting organization. The contract between the plan and an IRO must contain the following provisions:

- The IRO must agree to use legal experts where appropriate to make coverage determinations under the plan.
- The IRO must agree to timely notify the claimant in writing that the claim has been approved for external review and that the claimant has 10 business days to submit any additional information to be considered by the IRO. The IRO will send any such additional information to the plan within one business day following receipt. The plan may choose to reverse its prior denial based on the new information.
- The plan must agree to provide the IRO the plan documents and any information considered in issuing the denial. The documents and information must be provided within five business days after the plan assigns the review to the IRO, or the IRO may immediately rule against the plan. In that case, the IRO must notify both the claimant and the plan within one day after making the ruling.
- The IRO must agree to review all information and documents received without giving any deference to determinations made under the internal appeals process.
- The IRO must agree to provide written notice to the claimant and the plan within 45 days after the IRO receives the request for an external review. The notice must contain:
 - A general description of the reason for the request for external review;
 - The date the IRO received the request for review;
 - The date of the IRO's decision;
 - References to the evidence or documentation considered in the determination, including the specific coverage provisions and evidence-based standards;
 - A discussion of the principal reason or reasons for the decision, including the rationale for the decision and any evidence-based standards relied upon;
 - A statement that the determination is binding except to the extent that other relief is available under state or federal law;
 - A statement regarding the claimant's ability to file suit in federal court; and
 - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.
- The IRO must agree to maintain records of all claims and notices for six years and make such records available for examination by the claimant, plan or oversight agency upon request.



- The IRO must agree to make a determination of an expedited claim as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request.

Comply with the IRO's Determination. The IRO's decision is binding on the plan. If the IRO reverses the plan's denial of benefits, the plan must immediately provide coverage or payment for the claim.

Provide for Expedited Review in Certain Situations. If the plan denied a claim or appeal for benefits for a medical condition for which the exhaustion of the general appeals process would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the plan denied an appeal where the denial concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services and is still in a facility, the plan must immediately conduct an initial review of the external review request, notify the claimant and refer the claim to an IRO.

Comment: The DOL's safe harbor provides that the plan must take these actions "immediately," but it does not provide a specific timeframe.

CONSEQUENCES FOR FAILURE TO COMPLY

For plan years beginning on or after September 23, 2010, non-grandfathered group health plans must comply with both the current DOL regulations and the Interim Final Regulations when administering claims and appeals.

*Comment: Neither the Reform Legislation nor the Interim Final Regulations limit the requirements to **claims incurred** during the compliance period. Therefore, for example, a calendar year plan may be required to offer external review for a claim that was incurred in 2010 if the claim is still within the appeals process in 2011.*

The Reform Legislation mandates strict compliance. As a result, a group health plan will be subject to the following consequences if there is a failure to comply with any of the claims and appeals process requirements in the current DOL regulations or in guidance issued under the Reform Legislation:

Deemed Exhaustion of Internal Process. If a group health plan does not strictly comply with the requirements, a claimant will be deemed to have exhausted the internal claims process, which means that the claimant can immediately request an external review or immediately file suit in federal court.

Loss of Deference Standard. In most cases, a federal court will give deference to a plan administrator's benefit determination, overturning it only if the administrator's decision was arbitrary and capricious. However, if a plan violates any of the claims and appeals procedure



requirements, a court will review the claim de novo, making its own determination without giving the administrator's findings any deference.

Comment: The ability to request external reviews will likely reduce the volume of claims litigation. An external review likely will be more attractive than litigation because an IRO will conduct a de novo review at the plan's expense. If an IRO (which engages health care professionals knowledgeable about the services at issue) finds against the claimant, a judge likely would not substitute his or her non-medical judgment.

Tax Penalties. A failure to comply with the requirements will subject the plan to a \$100 per day excise tax. A plan that is subject to this excise tax must self-report the failure on Form 8928. Penalties and interest also may apply if a plan does not timely file Form 8928 and pay the excise tax. If a violation is corrected within 30 days of the date the plan knew or should have known of the violation, no excise tax is due.

RECOMMENDED ACTION STEPS FOR SPONSORS OF NON-GRANDFATHERED PLANS

All sponsors of non-grandfathered group health plans should ensure that summary plan descriptions are updated appropriately to describe the applicable internal claims and appeals process and external review process.

Sponsors of non-grandfathered self-insured group health plans should also take the following steps:

- Review service agreements with claims administrators to identify amendments needed to ensure that claims and appeals are processed in strict compliance with the current DOL claims procedures and the new Reform Legislation requirements.
- Reevaluate allocation of risk and liability between the plan and the third-party administrator in light of new requirements and consequences for failure to strictly comply with the requirements and determine whether any new or increased fees will be charged as a result of the new requirements.

Comment: In most cases, current claims and appeals processes, including preparation of EOBs and other notices of claims determination, will need to be modified in order to comply with the new requirements. Self-insured group health plan sponsors should discuss with their third-party administrators the changes that will be made and carefully review with their counsel the new form of EOB and/or other notices that will be provided to claimants.

- Start researching IROs to locate at least three organizations with which to contract.
- If appeals are administered in-house (whether through a committee or otherwise), consider whether it is feasible to achieve strict compliance with the applicable claims and appeals process requirements. If not, consideration should be given to delegating appeal authority to an outside administrator.



- To the extent appeal authority is delegated, ensure that plan language clearly and sufficiently delegates appeal authority to a fiduciary.

Comment: If authority is delegated to a committee or an outside administrator, it is critical that the plan have appropriate language to delegate the authority. Plan documents (and committee delegations, if applicable) should be reviewed by legal counsel.

FOR MORE INFORMATION

This bulletin was authored primarily by **Kim Wilcoxon**. Please contact any member of our **Employee Benefits & Executive Compensation** practice group for more information.

For more details on the Reform Legislation, please see our previous bulletins:

www.ThompsonHine.com/publications/publication2125.html

www.ThompsonHine.com/publications/publication2092.html

www.ThompsonHine.com/publications/publication2083.html

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