GROOM LAW GROUP CHARTERED

BENEFITS BRIEF

July 6, 2011 www.groom.com

Authors: Mark C. Nielsen and Christy A. Tinnes

If you have questions, please contact your regular Groom attorney or any of the Health and Welfare attorneys listed below:

Jon W. Breyfogle
jbreyfogle@groom.com
(202) 861-6641

Elizabeth T. Dold
edold@groom.com
(202) 861-5406

Thomas F. Fitzgerald
tfitzgerald@groom.com
(202) 861-6617

Anubhav Gogna
agogna@groom.com
(202) 861-2602

Cheryl Risley Hughes
chughes@groom.com
(202) 861-0167

Christine L. Keller
ckeller@groom.com
(202) 861-9371

Tamara S. Killion
tkillion@groom.com
(202) 861-6328

Mark C. Nielsen
mnielsen@groom.com
(202) 861-5429

William F. Sweetnam, Jr.
bsweetnam@groom.com
(202) 861-5427

Christy A. Tinnes
ctinnes@groom.com
(202) 861-6603

Brigen L. Winters
bwinters@groom.com
(202) 861-6618

Amendment to Affordable Care Act's Claims and Appeals Rules

The Departments of Labor ("DOL"), Health and Human Services ("HHS"), and Treasury (collectively, the "Agencies") recently released a long-anticipated amendment to the interim final rule (the "IFR") published last year governing the claims and appeals processes of insurers and group health plans under the Patient Protection and Affordable Care Act (the "ACA"). *See* 76 Fed. Reg. 37208 (June 24, 2011). The Agencies are accepting public comment on the amendment, which must be submitted by July 25, 2011. Additionally, the Agencies published separate guidance – in the form of Technical Releases – addressing the external review processes for insurers and self-funded group health plans.

As described in greater detail below, the amendment makes a number of important changes to the IFR, and provides, among other things, that:

- Urgent care claims must be decided in no more than 72 hours (instead of 24 hours, as was required under the IFR);
- Diagnosis and treatment codes, and their corresponding meanings, do not have to be listed on notices of adverse benefit determinations (reversing a requirement of the IFR, but must be provided upon request);
- A plan's internal appeals process will not be deemed exhausted based on *de minimis* violations of the IFR that do not cause prejudice or harm to the claimant (reversing another provision of the IFR);
- The numerical threshold that triggers a plan's obligation to issue claim and appeal notices in a "culturally and linguistically appropriate manner" is standardized;
- The scope of the federal external review process applicable to self-funded group health plans is narrowed to only denied claims involving medical judgments and rescissions (in contrast to the IFR, which subjected virtually all claim denials (other than those involving eligibility for coverage) to external review);
- Self-funded group health plans subject to the federal external review process must contract with at least two independent review organizations by January 1, 2012, and with at least three IROs by July 1, 2012; and
- A state's external review process does not have to satisfy the 16 consumer protections detailed in the IFR until January 1, 2014; prior to that date, the amendment establishes multiple "transition periods" during which state external review processes will be deemed compliant with the IFR if specified criteria are satisfied.

The Agencies also issued several model notices relating to adverse benefit determinations and external reviews that plans and insurers will likely find useful. The amendment is effective July 22, 2011, but the Agencies retain some of the earlier grace periods they had adopted, meaning that different provisions have varying applicability dates, which we describe below.

I. Background: The IFR's New Requirements for Claims & Appeals

On July 23, 2010, the Agencies published the IFR which implemented requirements imposed by the ACA with respect to benefit claims and appeals of denied claims. 75 Fed. Reg. 43,330 (July 23, 2010). The IFR applies to group health plans, insurance issuers offering group health insurance coverage, and insurance issuers offering individual policies, but does *not* apply to grandfathered plans. The IFR requires that plans and insurers comply with the existing DOL claims and appeals regulation (codified at 29 C.F.R. § 2590.503-1), and it sets forth a number of new requirements relating to claims and appeals with which plans and insurers must comply. The requirements of the IFR apply for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans), although, as we note below, the Agencies have issued "grace periods" with respect to some requirements (*see* DOL Technical Releases 2010-02 and 2011-01).

The IFR modified the existing DOL claims and appeals regulation in several respects and imposed a number of new requirements on plans and insurers. Specifically, the IFR imposed the following additional standards for internal claims and appeals processes:

1. The scope of an "adverse benefit determination" subject to the claims and appeals rules is expanded to include a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time);

2. The timeframe for deciding urgent care claims is reduced from a maximum of 72 hours, to 24 hours after receipt of the claim (the Agencies provided a grace period for this provision until plan years beginning on or after January 1, 2012);

3. Plan and insurers are required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan or insurer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale;

4. Plans and insurers cannot base decisions regarding the hiring, compensation, termination, or promotion of individuals such as a claims adjudicator or medical expert upon the likelihood that the individual will support the plan's denial of benefits;

5. Notices regarding claims and appeals must be provided in a "culturally and linguistically appropriate" manner, meaning that such notices have to be provided in an applicable non-English language if numerical thresholds set forth in the IFR are satisfied (the Agencies provided a grace period for this provision until plan years beginning on or after January 1, 2012);

6. Notices to claimants regarding the denial of a claim or appeal must provide additional content, including:

- information sufficient to identify the claim involved, such as the date of the service, the health care provider, the claim amount (if applicable),

- the diagnosis and treatment codes and their corresponding meanings;

- the denial code and its corresponding meaning, as well as a description of the plan or insurer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision;

- a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman; and

(The Agencies extended a grace period for this provision until plan years beginning on or after July 1, 2011, except for the requirement to provide diagnosis and treatment codes, which applies to plan years beginning on or after January 1, 2012.)

7. If a plan or insurer fails to strictly adhere to all the requirements of the IFR and even if there is a *de minimis* violation of the new rules, the claimant is deemed to have exhausted the plan or insurer's internal claims and appeals process, regardless of whether the plan or insurer has substantially complied with the IFR, and the claimant may initiate any available external review process or remedies available under ERISA or under state law. (The Agencies provided a grace period for this provision until plan years beginning on or after January 1, 2012).

The IFR also established rules relating to the external review process applicable to insurers and non-ERIA plans (the "State external review process"), as well as the external review process applicable to self-funded ERISA plans (the "federal external review process"). The Agencies subsequently issued Technical Releases describing the operation of the state and federal external review processes, and steps that plans had to take to comply with the federal process. A detailed discussion of the external review rules is available in our memorandum to clients dated August 25, 2010, which is available at: http://www.groom.com/resources-531.html

II. Changes to the Interim Final Rule

The recently issued amendment makes a number of important changes to the IFR and addresses many of the concerns raised by plans and insurers who filed comments with the Agencies. These changes to the IFR are summarized below.

A. Changes to the Internal Claim and Appeals Rules

1. Plans Have Up to 72 Hours to Review Urgent Care Claims

The Agencies eliminated the IFR's requirement that urgent care claims had to be decided within 24 hours. Instead, the amendment retains the current rule that urgent care claims must be decided as soon as possible, taking

into account medical exigencies, but no longer than 72 hours. Importantly, however, the Agencies emphasize in the Preamble to the amendment that the 72-hour window is an "outside limit and that, in cases where a decision must be made more quickly based on the medical exigencies involved, the requirement remains that the decision should be made sooner than 72 hours after receipt of the claim." The Preamble also clarifies that a plan or insurer *must* defer to a attending provider's determination as to whether a claim is "urgent."

2. Diagnosis and Treatment Codes Do Not Have to Be Included On Notices of Adverse Benefit Determinations

In one of the more significant revisions to the IFR, the Agencies eliminated the requirement that diagnosis and treatment codes, and their corresponding meanings, be disclosed on any notice of adverse benefit determination, such as an explantation of benefit ("EOB") statement. Commentators noted that the disclosure of such codes and their meanings raised raised significant privacy concerns and would impose significant claims reprogramming costs on plans and insurers.

Rather than requiring the automatic disclosure of diagnosis and treatment codes, the amendment provides that EOBs (and other notices of adverse benefit determinations) must inform participants that they may request the diagnosis and treatment codes (and their meanings), which must be provided following such request. The amendment emphasizes that a claimant's request for diagnosis or treatment codes is not, in and of itself, a request for an internal appeal or an external review. The new model notice of adverse benefit determination issued by the Agencies has language that plans and insurers may use to satisfy this requirement.

3. A Plan's Internal Appeals Process Will Not Be Deemed Exhausted Due to a De Minimis and Non-Prejudicial Error

In another significant change, the amendment reverses a provision in the IFR that provided a claim would be "deemed denied" – thereby allowing a participant to skip the plan's internal appeals process and move directly to either external review or court – if the plan or insurer failed to "strictly adhere" to any requirement set forth in the IFR, without regard to whether the claimant was harmed by the plan or insurer's error. Under the amendment, a violation of the IFR's rules will permit a claimant to seek immediate external or judicial review, unless the violation was:

- *De minimis*;
- Non-prejudicial;
- Attributable to good cause or matters beyond the plan or insurer's control;
- In the context of an ongoing, good faith exchange of information between the claimant and the plan or insurer; *and*
- Not reflective of a pattern or practice of non-compliance by the plan or insurer.

The amendment permits a claimant to request a written explantation of any violation from the plan or insurer. Upon receiving such a request, the plan or insurer must provide a written explantation to the claimant within 10 days – including a statement as to why the plan or insurer believes the violation should not cause its internal appeals process to be deemed exhausted.

If a claimant nonetheless skips the internal appeals process and files for external or judicial review, the external reviewer or court may reject the claimant's attempt at immediate review on the basis that the plan or insurer's violation was *de minimis*, in which case the amendment specifies that the claimant may resubmit the denied claim to the plan and pursue an internal appeal. The plan must notify the claimant of his or her right to resubmit the claim for internal appeal within 10 days after the external reviewer or court rejects the claimant's attempt at immediate external or judicial review, and the time period for refiling the claim begins to run upon the claimant's receipt of such notice.

4. The Numerical Trigger For "Culturally and Linguistically Appropriate" Notices Has Been Standardized

The amendment also creates a single standard for when plans and insurers must provide claim and appeal notices in a "culturally and linguistically appropriate manner," rather than requiring plans and insurers to determine whether they meet a particular threshold on their own. Under the amendment, plans and insurers are required to provide a notice as to the availability of services in a non-English language if – based upon data published by the U.S. Census Bureau (which will be updated annually) – 10 percent or more of the population residing in the claimant's county are literate only in the same non-English language. Plans and insurers with claimants residing in these identified counties are required to include a one-sentence statement on all claim and appeal notices in the applicable non-English language(s) that informs readers as to how they may obtain language assistance services in such non-English language(s). According to the model notice that the Agencies issued, this disclosure obligation may be satisfied by including the following sentence on claim and appeal notices in any applicable non-English language(s): "To obtain assistance in [insert non-English language], call [insert telephone number]."

Consistent with this notice requirement, a plan or insurer must provide oral language services – such as a telephone customer assistance hotline – where customer service representatives will answer questions in the applicable non-English language(s), and provide assistance with the filing claims and appeals (including external review) in any applicable non-English language.

According to the current Census Bureau list, which was issued as a part of the Preamble to the amendment, 255 counties in the United States satisfy the amendment's 10 percent threshold. Accordingly, plans and insurers should consult the list to identify if they have any claimants residing in such counties, so their notices of adverse benefit determinations may be appropriately modified.

B. Changes to the External Appeal Rules

1. The Scope of the Federal External Review Process Is Narrowed to Claims Involving Medical Judgmentand Rescission

With respect to the federal external appeal process that is generally applicable to self-funded ERISA plans, the amendment narrows the scope of appeals that are subject to external review. Under the IFR, "any" adverse

benefit determination (other than one involving eligibility) was subject to external review – even those claims that involved purely contractual issues, such as whether a procedure was excluded from coverage or the amount of cost-sharing applicable to a procedure. The amendment "suspends" this aspect of the IFR and provides that during this suspension period, only claims involving medical judgment and recissions will be subject to the federal external review process. The IFR notes that the state external review processes applicable to insurers in most states only are required to cover claim denials involving medical judgments and rescissions as well.

The amendment defines "medical judgment" to include claims for:

- Medical necessity;
- Appropriatness of care;
- Health care setting;
- Level of care;
- Effectiveness of a covered benefit; or
- Determinations as to whether a treatment or procedure is experimental or investigational.

Importantly, the amendment states that whether a claim involves a medical judgment is "determined by the external reviewer," which suggests that it is the independent review organization ("IRO") with which the plan contracts that may make the ultimate determination as to whether a claim is eligible for external review.

The amendment and its Preamble also suggest that the Agencies take a broad view as to what constitutes a claim involving medical judgment. An example to the amendment says that a claim denial based on a preexisting condition exclusion would be eligible for external review. In another example in the Preamble, the Agencies state that determinations as to whether a wellness plan participant is entitled to participate in a "reasonable alternative" program or activity to obtain a reward under a wellness program also will be considered a medical judgment determination eligible for external review.

2. Self-Funded Plans Must Contract With At Least Two IROs By January 1, 2012, and With Three IROs By July 1, 2012

Concurrent with the publication of the amendment, the Agencies issued Technical Release 2011-02, which provides an enforcement "safe harbor" for self-funded plans in the federal external review program. Under this new guidance, self-funded plans (or third party administrators for these plans) will be eligible for an enforcement safe harbor from the DOL and the Internal Revenue Service ("IRS") with respect to their external review processes if they have contracted with at least two IROs by January 1, 2012, and with at least three IROs by July 1, 2012.

Additionally, the Technical Release and the Preamble to the amendment make clear the Agencies' position that plans must rotate external review claims among their contracted IROs, to minimize the risk that one IRO may become dependent upon the plan. The Agencies specify that they "will look closely at any process other than rotational assignment" when determining whether a plan qualifies for the non-enforcement safe-harbor.

3. Transition Period for State External Processes

The amendment reiterates that insurers (and non-ERISA plans, such as a church plans and nonfederal governmental plans) will be required to comply with applicable state standards for external review and sets out the following schedule for compliance.

- *State External Review Exists (until December 31, 2011)* - The amendment provides that until December 31, 2011, any state external review process applicable to an insurer (or a non-ERISA plan) will be considered binding on the insurer and the plan and considered to meet the requirements of ACA § 2719(b) – which establishes 16 consumer protection standards that a state external review process must satisfy, based on the Uniform External Review Model Act (the "Uniform Model Act") issued by the National Association of Insurance Commissioners (the "NAIC").

- *No State External Review* - In those states and U.S. territories without any external review requirements – or where a state or territory's external review standards do not satisfy minimum requirements during a pre-2014 "transition period" (as discussed below) – insurers (and non-ERISA plans) in such states will be required to satisfy the federal external review process.

According to the Preamble, states and territories without external review programs are Alabama, Nebraska, Mississippi, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Marianas Islands.

- *State External Review (after December 31, 2011)* - From January 1, 2012 until January 1, 2014, state external review processes will be required to satisfy 13 specific consumer protection standards established by the NAIC Uniform Model Act, as designated in Technical Release 2011-02. In the Fall of 2011, HHS and DOL will publish a list of states whose external review processes are deemed to be compliant with the Agencies' guidance for the transition period.

If a state's external review process does not satisfy the 13 identified standards during the transition period, the insurer (or non-ERISA plan) must utilize the federal external review process. In such a case, insurers (and non-ERISA plans) may choose to participate in the federal external review process that is administered by HHS through an agreement with the Office of Personnel Management (referred to as the "HHS-administered process"), or through the private IRO process available to ERISA plans.

HHS issued separate guidance for insurers and non-ERISA plans as to how to elect the federal external review process administered by the Office of Personnel Management. According to this guidance, insurers and non-ERISA plans using the HHS-administered process must submit specific information regarding their election of such process to HHS via email by the earlier of (a) January 1, 2012, or (b) the date by which such insurers or plans use the federal external review process.

III. Additional Guidance Relating To the ACA's Claims and Appeals Rules

Simultaneous with publication of the amendment, the Agencies also published the following items relating to the ACA's claims and appeals rules:

- Model Notice of Adverse Benefit Determination, and an "Appeal Filing Form;"

- Model Notice of Final Internal Adverse Benefit Determination, and "External Review Filing Form;"
- Model Notice of Final External Review Decision; and
- Updated List of State "Consumer Assistance Programs"

Plans and insurers should consult these notices and the list of Consumer Assistance Programs for guidance as to updates that should be made to notices involving adverse benefit determinations. These materials can be found at www.dol.gov/ebsa.