

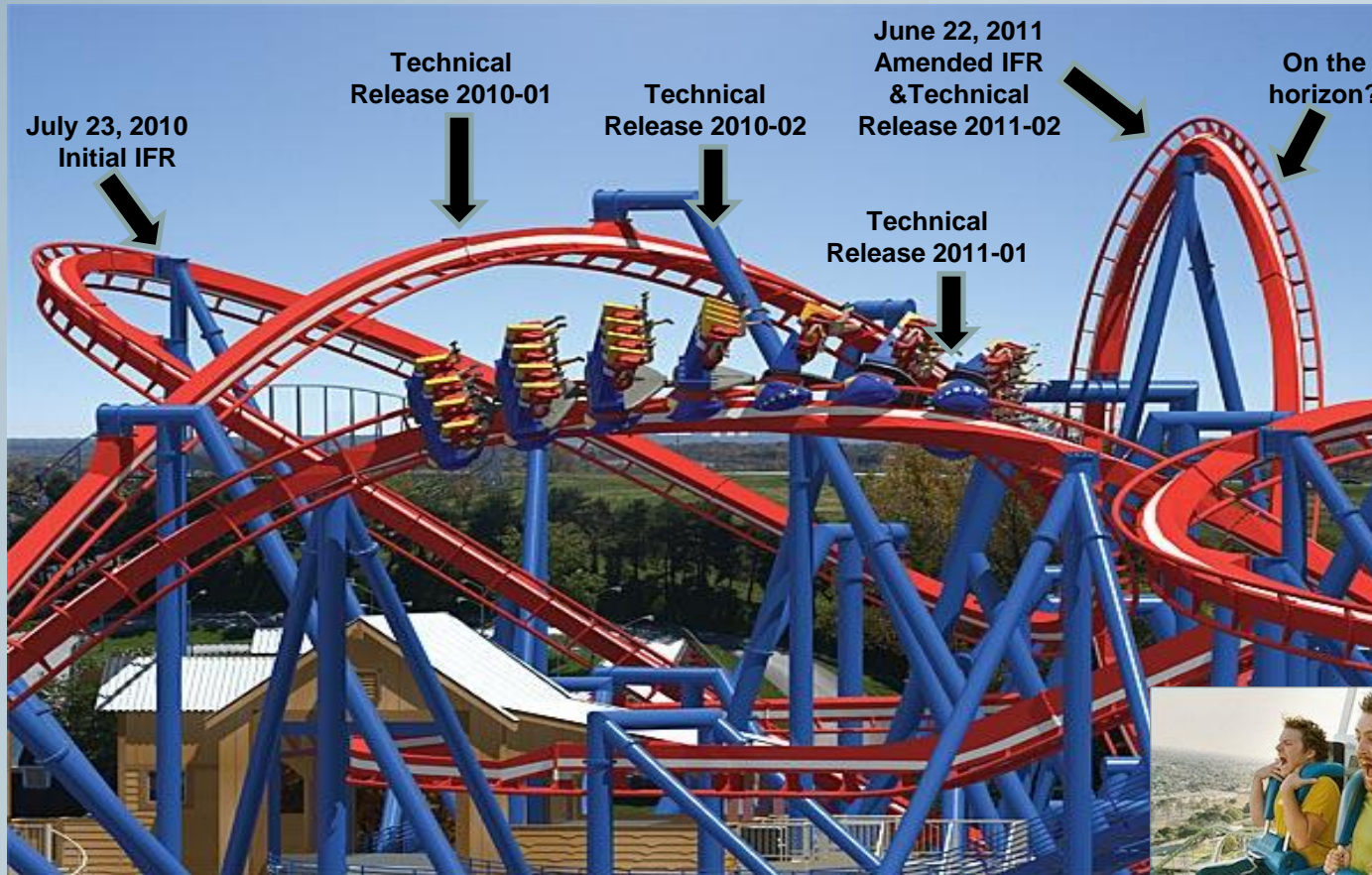
# American Benefits Council Preparing for PPACA Webinar

## Internal Appeals/External Review Regulations

(This Slide Set Focuses Solely on Internal Appeals)

*Seth T. Perretta*

# My interpretation of the claims and appeals guidance from start to not yet finished...



# Internal Claims and Appeals Discussion

## » Brief history

- Where the “ride” began

## » Current Guidance

- Where we are now... at least for now...

## » Important employer considerations and open issues

# Brief History

- » Long-standing claims and appeals rules with respect to ERISA plans
- » PPACA imposes new claims and appeals rules (as well as external review) via the IRC, ERISA and the PHSA on individual insurance policies as well as insured and self-insured group health plans
  - Note: New rules do NOT apply to grandfathered plans
- » The roller coaster of guidance:
  - On July 23, 2010, the Departments of Treasury, HHS and DOL issued an interim final rule (“IFR”)
  - Series of subregulatory guidance was issued by the agencies
    - Technical Release 2010-01
    - Technical Release 2010-02
    - Technical Release 2011-01
  - On June 22, 2011 (6/24 in Federal Register) issued amendments to the initial IFR, as well as Technical Release 2011-02

# Important New Internal Claims/Appeals Rules for ERISA plans

- » Generally effective July 22, 2011, but some provisions apply at varying times
- » **Important Provisions**
  - Definition of Claims Subject to Review
  - Urgent Care Claim Review
  - Availability of Diagnosis and Treatment Codes
  - Enhanced Notice Requirements
  - Continued Coverage Requirement
  - Strict Adherence Standard

# Definition of Claims Subject to Review

## » Existing ERISA rule

- An "adverse benefit determination" is generally defined to include a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for a benefit

## » Initial IFR

- Defines an "adverse benefit determination" to include a rescission of coverage regardless of whether the rescission adversely affects any particular benefit

## » Where we are now

- No change; same rule as set forth in the initial IFR dated July 23, 2010

# New Standard for Urgent Care Claims

## » Existing ERISA rule

- Requires that urgent care claims be decided as soon as possible and in no event later than 72 hours after submission

## » Initial IFR

- Provided that urgent care claims must be decided by a plan within 24 hours

## » Where we are now

- Amended IFR returns to the existing ERISA rule, *i.e.*, urgent care claims must be decided as soon as possible within the 72-hour window, BUT the preamble states:
  - Plan must follow provider's determination regarding status of claim
  - 72-hour window is “outside limit”



# Inclusion of Diagnostic and Treatment Codes

## » Existing ERISA rule

- No specific requirement; merely that the adverse benefit determination must set forth any internal rule, guideline, etc. relied upon

## » Initial IFR

- Required that all notices of adverse benefit determinations include the diagnosis and treatment codes and corresponding meanings

## » Where we are now

- Eliminates the requirement that plans automatically include diagnostic and treatment codes on notices
- BUT, must include a statement that the codes and their meanings are available upon request
  - Note: such a request cannot be treated as a request for internal appeal or external review



# Enhanced Notice Requirements

## » Existing ERISA rule

- No requirement to provide notices of adverse benefit determinations in any non-English language

## » Initial IFR

- Notices must be provided in a “culturally and linguistically appropriate manner,” *i.e.*, in a non-English language based on separate thresholds of the number of people literate in the same non-English language

## » Where we are now

- Sets a single, 10% threshold (of the number of people literate in the same non-English language) for both group and individual markets, based on Census Bureau data. Threshold is measured at level of the county of the residence of the claimant. Statements regarding the availability of non-English language assistance must be placed on notices, in the relevant non-English language (either Spanish, Chinese, Tagalog or Navajo)

# Continued Coverage Requirement

## » Existing ERISA rule

- Generally, there is no requirement that a plan continue to provide coverage with respect to a contested benefit for the full duration of internal review, except in the cases of concurrent care in which case advance notice is required

## » Initial IFR

- Adopts existing rule and applies it to non-ERISA plans and policies

## » Where we are now

- No change; same as set forth in July 23, 2010 IFR

# New Strict Adherence Standard

## » Existing ERISA rule

- Pursuant to the federal common law doctrine of “substantial compliance”, courts have generally held that an individual may not avoid exhausting any internal claims and appeals process (including that prescribed by the ERISA claims procedures) and go straight to federal court to enforce their rights if the plan was in “substantial compliance” with the applicable claims procedures
  - Sound basis for the rule – encourages resolution of claims at the earliest and most cost-effective stage
  - DOL concerned courts have gone too far with the rule

## » Initial IFR

- Permitted individuals to proceed directly to external review or federal court, to the extent a plan fails to strictly adhere to the claims/appeals and external review rules
  - Turns system on its head; pushes resolution to more costly and less efficient procedural stage

# New Strict Adherence Standard

## » Where we are now

– Per the amended IFR, an individual continues to be able to skip internal claims and appeals and proceed directly to external review and/or federal court in the event a plan fails to strictly adhere to the new claims and appeals rules, except where ALL of the following criteria are satisfied:

- *De minimis* violation
- Participant is not prejudiced or harmed by the violation regarding his right to external review
- Violation is attributable to good cause or is outside of plan's control
- No existing pattern or practice of non-compliance by the plan
- Part of ongoing good faith exchange of information

# New Strict Adherence Standard

## » Where we are now (cont'd)

### – Additional rules

- To the extent a plan is asserting that the violation does not give the claimant a right to proceed directly to external review or federal court, as appropriate, a claimant may request in writing, and must receive from the plan within 10 days, a written explanation of the bases for the plan's assertion that such violation does not give rise to deemed exhaustion of the claims procedures
- If an individual goes to external review or federal court and the IRO or the court, as relevant, rejects a claimant's request for immediate review based on the violation being *de minimis*, the claimant may re-file his or her claim for internal review.
  - A plan must notify a claimant of such right within 10 days following an IRO's or court's determination
  - The claimant's 10-day "window" for resubmitting a claim for internal review does not begin until noticed by the plan

# New Strict Adherence Standard

## » Where we are now (cont'd)

### – Additional rules

- The amended IFR retains language providing that if a plan does not make available a reasonable internal appeals process that permits a proper adjudication of the merits of the claim, an IRO or federal court may review the claim *de novo*, *i.e.*, without deference to any prior determinations by the plan
  - Under existing federal common law, reviewing courts are generally highly deferential to plan determinations, *i.e.*, *de novo* review of claim is highly unusual

Seth T. Perretta  
(202) 624-2500  
sperretta@crowell.com

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**James R. Napoli**

July, 2011



## External Review

- ❑ Applies to non-grandfathered plans effective with the first plan year beginning on or after September 23, 2010
  - ❑ External claims procedures mandate:
    - ❑ Plans will need to comply with either state or federal external review process (transition rules apply for fully insured and self-funded plans)
    - ❑ Plans must establish an external review process with consumer protections similar to those in the Uniform External Review Model Act developed by the NAIC, and comply with additional requirements as provided by HHS
    - ❑ Process must provide for expedited external review and additional consumer protections with respect to claims involving experimental or investigational treatment
    - ❑ Participants have 4 months to request an external review after receiving a final adverse benefit determination
    - ❑ Additional guidance on external appeals process forthcoming



## External Review

- ❑ External claims procedures mandate:
  - ❑ Technical Release 2010-01 establishes a safe harbor for compliance with external appeals requirements
  - ❑ Two possible safe harbors:
    - ❑ 1. Voluntary compliance with state external review process, i.e., self-insured plan subjects itself to state law requirements
    - ❑ 2. Compliance with TR 2010-01
      - ❑ Multi stage review
      - ❑ Contract with 3 different IROs with specified agreements (Technical Release 2011-02 provides that a plan will be eligible for the safe harbor if it contracts with at least two IROs by January 1, 2012 and at least three IROs by July 1, 2012)
  - ❑ FAQs clarified that facts and circumstances will prevail



## External Review

- ❑ External claims procedures mandate:
- ❑ Changes to the external claims procedures mandate under the June 2011 amendment and DOL Technical Release 2011-02 include:
  - ❑ Revisions to model notices for external adverse benefit determinations
  - ❑ External reviews initiated prior to September 20, 2011 - all adverse benefit determinations (including rescission) except:
    - ❑ benefit denial based on a determination that individual is not eligible for benefits under the terms of a group health plan (e.g., worker classification)
  - ❑ External reviews initiated on or after September 20, 2011 – limited to adverse benefit determinations based on medical judgment or that involve a **rescission** of coverage.
    - ❑ Those involving only contractual or legal interpretation are excluded



## What is a Rescission of Coverage?

- Rescission = a retroactive termination of coverage for any reason except:
  - **fraud or intentional misrepresentation of material fact** (if prohibited by the terms of the plan)
  - Failure to pay premiums is not a rescission of coverage
  - Retroactive termination under normal COBRA processes permitted; but not necessarily for mistaken administration outside of the normal COBRA process



## What is a Rescission of Coverage?

- Rescission Example:
  - Plan covers only full-time employees. On audit, plan discovers that employee was incorrectly classified as full-time. Coverage may be canceled prospectively, but plan cannot rescind retroactively to when the individual lost full-time status, since there was no fraud or intentional misrepresentation of material fact
- Adding rescission to the scope of external review appears to broaden the scope of review in that some rescissions are based on a failure to qualify for coverage.



## External Review

- Additional changes to the external claims procedures mandate:
- HHS will determine each state's compliance with either:
  - 1) Standards meeting all the consumer protections in the NAIC Uniform Model Act, or
  - 2) Temporary processes similar to the NAIC standards
    - Existing state external review processes are deemed compliant until December 31, 2011
    - By January 1, 2012, plans must have implemented an external review process that complies with (1) or (2) above, or otherwise a federally administered external review process will apply
- If a state's external review process does not meet (1) above by January 1, 2014, the federally administered external review process will apply for that state





## Contracting with IROs

- Contracting with IROs
  - Plan may contract directly with IROs or indirectly through a TPA
  - Contracting IROs through a TPA does not relieve plan fiduciaries of their oversight responsibilities
    - Perform due diligence with respect to the selection of IROs
    - Continued monitoring of IROs by appropriate plan fiduciary
    - Indemnification issues
  - Keep fiduciary structure in mind when contracting IROs and setting up external appeals procedures under the plan
  - Keep an eye on the indemnities and where they run



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James R. Napoli  
jnapoli@proskauer.com  
202.416.5862

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