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employee benefits & executive compensation alert

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Our Employee Benefits and Executive Compensation attorneys have a diversified national practice. We assist clients of all shapes and sizes - businesses in virtually every industry sector, 501(c)(3)s and other tax-exempt organizations, and governmental entities under 414(d) - on compensation and benefit-related issues.

Material Changes Now, More Material Changes Coming

(What's happened to group health plan claims and appeals?)

What's happened?

The Departments of Labor (DOL), Treasury, and Health and Human Services recently issued rules that materially modify the requirements for health claim and appeal reviews beginning as early as September 23, 2010.[1] These recently issued rules apply to non-grandfathered group health plans whether or not they are governed by ERISA. In addition, according to the preamble for these rules the DOL is also considering further updates to the existing ERISA claims regulation and "expects to issue future regulations that will propose additional, more comprehensive updates to the standards for plan internal claims and appeals processes."[2] These updates are expected to apply to both grandfathered and non-grandfathered plans.

What do I need to do now?

If your company, governmental unit, or church sponsors a non-grandfathered group health plan, including a plan that is not governed by ERISA, the new requirements in the recently issued rules apply to it and you need to:

- Review your group health plan vendor contracts to see if they need to be amended, given the required modifications described below.
- Negotiate new contract terms with these vendors, where necessary.
- Monitor these vendors for compliance with the new rules.

If your group health plan is grandfathered, you need to understand that the changes discussed below may well foreshadow coming changes in the form of an updated ERISA claims regulation that will apply to your plan.

How are these rules structured?

The rules describe:

- The requirements for the internal claims and appeals review process.
- The standards for state and federal external appeals processes.

The internal claims and review process described in the new rules applies the existing DOL claims regulation, modified as described below, to both insured and self-insured non-grandfathered group health plans.[3] It will also apply, for the first time, to group health plans that are not governed by ERISA, such as government and church plans.

The standards for the state external review procedure applicable to insured plans, which are also described below, are detailed.[4] If the federal government determines that the state external review process does not meet the requirements of the rules, the federal external review process, which applies to self-insured group health plans, will also apply to insured group health plans. Finally, while the rules do not describe the federal external review process in detail, they indicate that it will look very similar to the rules for qualifying state processes.

What are the new internal review requirements?

In addition to the requirements under the existing claims regulation, the following requirements will apply to both insured and self-insured non-grandfathered group health plans beginning the first plan year on or after September 23, 2010, or January 1, 2011 for calendar year plans.

Strict Adherence. If the decision maker does not strictly adhere to all requirements of the internal claims and appeals processes, the claim is deemed denied without the exercise of discretion by a fiduciary and the claimant may proceed to the external process. This is true even if the decision maker substantially complies with the internal process or the errors made are *de minimis*.

Full and Fair Review. A claimant must be allowed to review the claim file and present evidence and

testimony as part of the review process. A claimant must be provided, free of charge, any new or additional evidence and any new rationale on appeal as soon as possible and sufficiently in advance of the final determination to give the claimant a reasonable opportunity to respond before the final determination is issued.

Languages Other Than English. Notice to claimants must be provided in a culturally and linguistically appropriate manner. Accordingly, if a certain number or percentage of plan participants are literate only in a non-English language, the plan must provide notice in that non-English language.

Additional Content. Each notice of an adverse benefit determination must include: the date of the service; the health care provider; any applicable claim amount; the diagnostic, treatment, and denial codes, and the meaning of those codes; a description of any applicable standard, such as the standard for medical necessity; a discussion of the decision; a description of the internal and external review procedures and how to initiate an appeal; and contact information for any applicable office of health insurance consumer assistance or ombudsman.

Avoiding Conflicts of Interest. The plan must ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the people involved in the decision making. Accordingly, a medical expert must not be hired based on the expert's reputation for outcomes in contested cases and individual employment decisions about people who make benefit determinations must not be based on the likelihood the individual will deny claims.

Urgent Care Notification. A claimant must be notified of the grant or denial of an urgent care claim as soon as possible, but not more than 24 hours after receipt of a claim. Grandfathered group health plans currently have up to 72 hours.

Continued Coverage. An ongoing course of concurrent treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

Adverse Benefit Determination Defined. The definition of adverse benefit determination has been broadened to include a rescission of coverage.

What are the new external review requirements?

The minimum standards for state external review procedures that apply to non-grandfathered insured plans are very detailed. The state external review procedures:

- Must cover all adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- Must provide effective written notice in 45 days or less.
- Must provide expedited review – as soon as possible but not more than 72 hours after receipt of a request – if the standard response time would seriously jeopardize the health or life of the claimant or jeopardize the claimant's ability to regain maximum function.
- Must include certain limits on any exhaustion requirement.
- Must not make a claimant pay more than a nominal filing fee for review - and this nominal fee is subject to reimbursement, waiver, and annual limit provisions.
- Must not restrict review to claims over a certain dollar limit.
- Must allow a claimant at least four months to file an appeal.
- Must assign independent review organizations (IROs) in a manner that assures independence and impartiality, such as random assignments.
- Must provide for the maintenance of a list of approved IROs that are nationally accredited and have no conflicts of interest.
- Must allow the claimant at least five business days to provide additional information to the IRO and must notify the claimant of this right.
- Must require IROs to keep written records for certain periods.
- Must provide that the determination is binding on the parties.
- Must require a description of the external appeals process in the summary plan description, certificate, or other evidence of coverage.

What are the new federal external review requirements?

The new federal external review requirements that apply to non-grandfathered self-insured plans (and non-grandfathered insured plans if the state external review process is not deemed sufficient by the federal government) will be similar to the process in the NAIC Uniform Model Act. The NAIC process is similar to the requirements for a state external review process described above. The new federal external review requirements will describe:

- How a claimant initiates external review.

- Procedures for determining whether a claim is eligible for external review.
- Minimum qualifications for IROs and a process for approving IROs.
- A process for random assignment of IROs.
- Standards for IRO decision making.
- Rules for providing notice of a final external decision.

May we help?

We would be happy to answer any questions you may have regarding the internal and external claims and review processes, the effect of the health care reform laws on your plans, or any other employee benefit issue.

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(1) The interim final rules issued by the three agencies can be found at 75 Federal Register 43330 (July 23, 2010)(to be codified at 26 C.F.R. pts. 54 and 602, 29 C.F.R. pt. 2590, and 45 C.F.R. pt. 147).

(2) 75 Fed. Reg. 43332 (July 23, 2010).

(3) The existing claims regulation can be found at 29 C.F.R. § 2560.503-1.

(4) There is a transition period for plan years beginning before July 1, 2011 during which existing state external review procedures are deemed to meet the requirements of the regulation.

Please contact any of the attorneys in our Employee Benefits & Executive Compensation group if you have any questions regarding this alert.

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