McGraw Wentworth

REFORM Update

Issue Thirteen August 2010

August 9, 2010

The Joint Agency Task Force recently released regulations to address the internal and external claim review requirements that were outlined in the health care reform acts. These new requirements are effective the first day of the first plan year following September 23, 2010. The effective date of these requirements can be delayed for grandfathered plans.

These new requirements will affect plans differently. If your plan is currently subject to ERISA, your internal review process will be modified but not completely changed. If your plan is not subject to ERISA, your plan will need to adopt all of the ERISA claim review procedures, in addition, to the modifications made by health care reform. The external review will affect plans differently as well. Much will depend on whether your plan is fully insured or self-funded and your state's current external review process.

This *Update* will summarize the new requirements for claims reviews as spelled out by this latest round of guidance.

Definitions

The regulations include a number of definitions to help employers understand the terms used:

- ***Adverse benefit determination*** means a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit; including if a denial, reduction or termination or failure to make payment is based on the determination of participant's or beneficiary's eligibility to participate in the plan. The new regulations add that a rescission of coverage is considered an adverse benefit determination, even if there is not an adverse effect on any particular benefit at the time.
- ***Appeal (or Internal Appeal)*** means a review by a plan or insurer of an adverse benefit determination.
- ***Claimant*** means an individual who submits a claim to a plan and includes a claimant's personal representative.
- ***External review*** means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State external review process or a federal external review process.
- ***Final internal adverse benefit determination*** means an adverse benefit determination that has been upheld by a plan or insurer at the completion of the appeals process or adverse benefit determination in which the internal appeals process has been deemed "exhausted".

- ***Final external review determination*** means a determination by an independent review organization (IRO) at the conclusion of an external review.
- ***Independent review organization*** means an entity that conducts independent external reviews of adverse benefit determinations and final adverse benefit determinations.
- ***NAIC Uniform Model Act*** refers to the Uniform Carrier External Review Model published by the NAIC and in place on July 23, 2010.

These definitions will be important to understand as we discuss the internal and external review requirements.

Internal Claim Review and Appeals

The health care reform acts require all group health plans, group health insurance carriers and individual health insurance carriers to implement an effective internal claims and appeals process. For group health plans and health insurance insurers, the starting point of the regulations requires compliance with ERISA claim review and appeal procedures. These procedures are fairly detailed and complex. For the details of ERISA medical plan claim requirements, please read Issue 4 of our *Benefit Advisor* from 2002 at http://mcgrawwentworth.com/Benefit_Advisor/2002/Issue%20Four.pdf.

These regulations made some changes to the ERISA claim review and appeal procedures. Your claim process must be modified to address the following changes required by health care reform:

- The definition of adverse benefit determination must be modified to include rescissions of coverage.
- The plan must provide expedited notifications for benefit determinations associated with urgent care. Initially, the ERISA claim procedures required the plan to respond to a benefit determination related to urgent care within 72 hours after receiving a claim. These regulations require a plan or insurer to notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account medical exigencies, but no later than 24 hours after receipt of the claim by the plan or insurer. More time is allowed if the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. Urgent care claims are defined by ERISA as a claim that involves urgent care and if the timeframe for making non-urgent claim determinations could seriously jeopardize the claimant's life, health or ability to regain maximum function or if in the opinion of a physician with knowledge of the claimant's medical condition that the claimant would be subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- A plan or insurer must allow a claimant to review the claim file and present evidence and testimony as part of the internal claim review and appeal process. This is in addition to all the current ERISA requirements for claims reviews and appeals. The plan must also address these additional requirements:
    - The plan must provide the claimant, free of charge, any new or additional evidence used, relied upon or generated by the plan or insurer in connection with the claim. Such evidence must be provided to the claimant as soon as

reasonably possible and sufficiently in advance of the date in which the final adverse benefit determination is required to be provided by ERISA.

- Before a plan can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided free of charge with the rationale. This information must also be provided as soon as reasonably possible and sufficiently in advance of the date in which the final adverse benefit determination is required to be provided by ERISA.

- The plan and insurer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independency and impartiality of the persons involved in making benefit determinations. As such, employment decisions regarding hiring, compensation, termination, promotion, or other similar matters must not be made based upon the likelihood that the individual will support a claim denial.
- A plan must provide a notice of any adverse claim determinations. ERISA has a number of requirements that apply to communications with a claimant in regard to benefit determinations and appeals. These new regulations add a number of new requirements to the communication process:
  - A plan or insurer must provide notice to individuals in a culturally and linguistically appropriate manner that meets the requirements of ERISA, plus the new requirements in these regulations, include:
    1) Notice of an adverse benefit determination or a final notice of an adverse benefit determination must include information sufficient to identify the claim, such as the date of service, health care provider, the amount of the claim, the diagnosis and treatment codes and their corresponding meanings.
    2) The plan and insurer must make sure that the reason for the denial includes a denial code and its associated meaning, as well as a description of the plan standard, if any, that was used in denying the claim.
    3) The plan must provide a description of the available internal appeals and external review processes, including information on how to initiate an appeal.
    4) The plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act to assist individuals with internal claims and appeals as well as the external review process.
- If a plan or insurance carrier fails to strictly adhere to the claim process requirements under ERISA and the amendments made by health care reform, the claimant is deemed to have exhausted the internal claims and appeals process. The plan's failure to meet the requirements means the claimant need not exhaust remedies in the internal process, and they can seek an external review (addressed in the next section). The claimant can also seek remedies under ERISA or available under state law.

- Finally, a plan is required to continue coverage pending the outcome of any appeal. This point references an ERISA provision that generally provides benefits for an ongoing course of treatment that cannot be reduced or terminated without providing advance notice or an opportunity for advance review.

The good news for most ERISA plans is that your insurance carrier or third party administrator is likely to amend their process to include these changes to their current claims and appeals procedures.

For non-ERISA plans, you may need to review your plan's current claims review and appeals process. Again, your carrier or third party administrator will be instrumental in assisting your plan in meeting these requirements.

External Review Process

Addressing the external review process will be interesting for most plans and the action steps will differ based on your plan status. The health care reform acts sets forth a requirement that health plans have an external review process that participants can use if they are unable to get a claim paid by using the internal claim review process discussed above.

Most states have some sort of external review process that applies to specified fully insured plans in the state. Self-funded plans have historically been excluded from state external review programs due to ERISA preemption. The only states that have no external review requirements as of today are Alabama, Mississippi, Nebraska, North Dakota, South Dakota and Wyoming. Some state external review requirements apply only to HMO business in the state and not all group insurance products.

Michigan does have an external review process that is administered by the Office of Financial and Insurance Regulation (OFIR). The process applies to carriers that do business in the state. However, the existence of the external review process may not be common knowledge among Michigan residents.

The new external review regulations will achieve the following:

1. Require states to modify their current external review process to meet the requirements of these regulations. For external review processes that don't currently meet the minimum requirements, they will have until July 2011 to meet the requirements to be considered compliant with these regulations.
2. Require self-funded plans and fully-insured plans in states that do not have a compliant external review process to use a federal external review process which is still being created.

State External Review Requirements

The state process must meet all the required consumer protections and provide for an external review of adverse benefit determinations (including final determinations) decided by insurance carriers when the denial is based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of covered benefit.

The state process must, at a minimum, meet the following requirements:

- States must require insurers to provide an effective written notice to claimants of their rights in connection with an external review for an adverse claim determination.
- If the state process requires the exhaustion of the internal claims and appeals process, exhaustion will be unnecessary if the insurer has waived the requirement, the insurer does not follow the requirements of the law and the process is deemed exhausted, or if the claimant applies for expedited external review at the same time the claimant applies for expedited internal review.
- The state process should require the insurer or the plan to pay the cost associated with an IRO (independent review organization) for the external review. The state may require a nominal fee from the claimant in order to submit a claim for external review. In order for a fee to be considered nominal it must not be more than $25 and it must be refunded if the external review results in the benefit determination being reversed. In addition, the fee must be waived in cases of financial hardship and the annual limit on charging filing fees related to one claimant must be capped at $75 in a single plan year.
- The state process may not impose a restriction on the minimum dollar amount of a claim that is eligible for external review.
- The state process must allow, at a minimum, a four month window for a claimant to submit an external review request, measured from the date of receipt of the final adverse benefit determination.
- The state process must allow IROs to be assigned on a random basis or utilize another method that ensures the independence and impartiality of the assignment by the state. Under no circumstances should the IRO be selected by the insurer, plan or claimant.
- The state must provide a list of the approved IROs qualified to conduct an external review based on the nature of the health care service that is the subject of review. The state can only use IROs that are accredited by a nationally recognized private accrediting organization.
- The state must verify that any approved IRO has no conflict of interest that may influence the impartiality of their decision. For example, the IRO may not own or control or be owned or controlled by a health insurance carrier, a trade association of plans or carriers, and so on. The state must also confirm the IRO does not have a personal conflict of interest.
- The state process must allow, at a minimum, five business days for the claimant to submit additional information to the IRO and the state is required to notify the claimant of this right. The state must also require that any additional information submitted directly to the IRO be forwarded to the insurer within one business day of receipt.
- The state process must provide that the decision of the external review is binding on the insurer and the claimant, except to the extent other remedies are available under state or federal law.

- The state process must require that for standard external review the IRO provide written notice of its decision to uphold or overturn the adverse benefit determination to the insurer and the claimant within no more than 45 days after the receipt of the request to conduct an external review.
- The state must require a more expedited external review of the adverse benefit determination that concerns an admission, the availability of care, a continued stay or a health care service for which the claimant received emergency services but has not been discharged from a facility. A more expedited external review must be provided in situations for which the standard external review timeline would seriously jeopardize the life or health of the claimant or the ability for the claimant to regain maximum function. An expedited review must be processed as soon as possible but no later than 72 hours after the receipt by the IRO of the request for an expedited review. Once the IRO makes the decision, it must provide notice within 48 hours to the insurer and the claimant.
- The state must require the insurer include a written description of the external review process in or attached to the summary plan description, the policy, the certificate, membership booklet, outline of coverage, and so on.
- The state must require the IROs to maintain written records and make them available to the state upon request following rules set forth in NAIC Uniform Model Act.
- The state process must follow rules set forth in NAIC Uniform Model Act with external reviews for adverse benefit determinations involving experimental or investigational treatment.

The requirements of these regulations may be more expansive than a state's current external review program. The regulations do include a transitional period. For plan years beginning before July 1, 2011, the applicable state review process that pertains to a health insurance carrier or health plan is considered to meet the requirements noted above. The regulations do note for plan years beginning before July 1, 2011, the decision of the IRO is binding. This transition guidance will provide states time to make any modifications needed to their external review programs to meet the requirements noted above.

For the six states that do not have an external review program, those states will be required to use the Federal External Review Program discussed below.

Federal External Review Program

For final adverse benefit determinations provided after the first day of the first plan year beginning on or after July 1, 2011, the federal external review process will apply unless the Department of Health and Human Services determines that the state review process applies to your plan and meets all the requirements listed above.

The federal external review process will apply to:

- Self-funded medical plans.
- Fully-insured plans in states that do not have a state external review requirement.

- Fully-insured plans in states where the external review requirements fail to meet the conditions listed in the previous section.

The federal external review process will apply if the denial is based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of covered benefit. It will not apply if the reason for the failure to pay the claim is based on the determination that the participant fails to meet the eligibility requirements of the plan.

The Secretary of the Department of Health and Human Services will need to issue standards to create the federal external review process. The regulations do specify the federal review program will need to follow the basic guidelines that apply to state external review processes as outlined in the previous section. The standards must include the following information:

- Describe how a claimant can initiate a federal external claim review.
- Procedures for a preliminary review of the claim to determine if the claim is eligible for an external federal review.
- Minimum requirements for an IRO along with a process for assigning an IRO, addressing potential conflicts of interest, standards for IRO decision-making and a process to communicate the final determination of the IRO.
- An expedited external review process will be created for situations where the claimant's life or health would be jeopardized by following the normal review timeframes. Expedited review will also be available for adverse claim determinations involving an admission, availability of care, continued stay or for a situation where a claimant received emergency services but has not been discharged from the facility.
- For claim reviews that involve experimental or investigational treatments, these standards will also provide consumer protections to ensure adequate clinical and scientific experience and scientific protocols are taken into account as part of the review.
- These standards will provide that the external review decision is binding on the health plan, insurer, if applicable, and claimant except to the extent other remedies are available under state or federal law.
- These standards may establish external review reporting requirements for IROs.
- These standards will establish additional notice requirements for plans and insurers regarding disclosures to participants and beneficiaries describing the federal external review procedures. This information will need to be included in key benefit communications, such as the summary plan description.
- The standards will require plans and carriers to provide information relevant to the processing of the external review, such as information used to make a final adverse benefit determination.

The federal external review process will take more time to create than the state process. The majority of states already had a state external review process that may only need to be amended. The federal process is being built from scratch and we expect more details to be released in the months to come.

Notice Language Requirements

Interestingly, these regulations include the requirement that the notices provided during the review process be "culturally and linguistically appropriate". For the purposes of these regulations, relevant notices are considered "culturally and linguistically appropriate" if:

- For a plan that covers fewer than 100 participants at the beginning of a plan year, the plan and insurer must provide notices upon request in a non-English language only if 25% or more of all plan participants are literate only in the same non-English language.
- For a plan that covers 100 or more participants at the beginning of a plan year, the plan and insurer must provide notices upon request in the non-English language that the lesser of 500 or more participants or 10% or more of plan participants are literate only in that non-English language.
- If a plan is required to provide notices in a non-English language upon request, the plan must include a statement in all English language notices, prominently displayed in the non-English language, that the notice is available in the non-English language.
- Once the plan provides the notice in a non-English language, all subsequent notices relating to claims and appeals must be provided in the non-English language.
- If the plan or insurer maintains a customer service process, such as a telephone hotline, to answer questions or provide assistance with filing claims, the plan must provide such assistance in the non-English language.

For the most part, employers can rely on carriers to provide the required notices in the appropriate language, however, your organization will need to be aware of the prevalence of your non-English speaking employees. In addition, the final bullet is a bit concerning and hopefully clarification will be forthcoming. It seems to imply if your organization assists employees with claims that such assistance must be provided in the non-English language. However, it is not particularly clear if this requirement will apply directly to employers that provide occasional assistance to employees with claim issues.

Concluding Thoughts

The new appeal requirements are designed to ensure all plan participants are afforded a full and fair review of their claims and any appeals to the plan of adverse benefit determinations. ERISA plans have long been held to very specific standards in regard to the claims review and appeals process. These plans will need to make some amendments to their process in order to meet the new requirements.

The good news for employers is that a large portion of the new appeal requirements will be handled by your insurance carrier or third party administrator. However, your organization should confirm with your vendor that their process will meet the requirements of ERISA and these new regulations.

The effective date for external claim reviews appears to be extended by these regulations. If your plan is fully insured and currently subject to a state external review process, this process will continue as is and be deemed to meet these regulation requirements until the first day of the first plan year

beginning on or after July 1, 2011. States will have to make the required changes by July 1, 2011 to be compliant with the new process.

The effective date for the federal external review is also extended. The federal external review program will apply to final adverse benefit determinations provided after the first day of the first plan year beginning on or after July 1, 2011. This will provide the federal government time to build and launch the federal review process.

We will likely hear more about the external review process in the coming year.