

Health Care Reform Update

Regulations Issued Addressing Claims and Appeals Procedures

The Departments of Labor, the Treasury and Health and Human Services issued an interim final rule for group health plans and health insurance carriers relating to internal claims and appeals procedures and external review processes under the Patient Protection and Affordable Care Act (PPACA).

Briefly, the lengthy and rather complicated regulations:

- Only apply to non-grandfathered coverage effective for the first plan year that begins on or after September 23, 2010 (with some limited transition relief);
- Build on current ERISA claims and appeals procedures (discussed below and in the attached *Appendix*) by adding six new requirements;
- Impose the ERISA claims and appeals procedures, including the new requirements, on plans that are not otherwise governed by ERISA (e.g. non-federal government group health plans, church plans, individual insurance policies¹);
- Require a group health plan or health insurance carrier to continue coverage pending the outcome of an appeal;
- Provide for either a State or Federal level external review of claims and appeals decisions; and
- Set forth a form and manner for providing notices in connection with internal claims and appeals and external review processes.

The following summary provides additional detail on these new requirements.

INTERNAL CLAIMS AND APPEALS PROCESS

All non-grandfathered group health plans and health insurance carriers providing group health plan coverage will need to comply with the ERISA claims procedures and the following additional requirements:²

1. The regulations expand the definition of an *adverse benefit determination*³ to include a rescission of coverage.

¹ This summary does not address the claims and appeals regulations as they affect individual health insurance coverage.

² Non-grandfathered group health plans that are not subject to ERISA (e.g. non-federal government plans, church plans) will need to comply with the ERISA claims procedures and additional modifications made by the PPACA.

³ See 29 CFR 2560.503-1(m)(4) for the definition of an *adverse benefit determination*. By referencing the ERISA claims procedure regulations, an *adverse benefit determination* eligible for internal claims and appeals process under these regulations includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or

2. A new deadline will require a plan to notify a claimant of a benefit determination (whether adverse or not) with respect to an urgent care claim within 24 hours after receipt of the claim (this is a change from 72 hours), unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.
3. As part of a full and fair review, the claimant must be provided with any new or additional evidence relied upon or generated by the plan (or insurance carrier) in connection with the claim. Further, any rationale for an adverse benefit decision must be provided to the claimant. Both of these provisions require that such evidence or rationale is provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefits determination on review is required to be provided to give the claimant a reasonable opportunity to respond.
4. Implement mechanisms to avoid a conflict of interest. This provision requires that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the decision makers. As such, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be based on the likelihood the individual will support a denial of benefits (e.g. an insurance carrier may not provide additional compensation to a claims adjudicator based on the number of claims he or she denies).
5. New content requirements for adverse benefit determinations have been added that include, among other things, sufficient information to Identify the Claim (e.g. date of service, health care provider, diagnosis or treatment code and the meaning of any such code); the Reason for Denial (e.g. denial code and the meaning of a denial code, a description of the standard used in denying the claim); the Availability of Internal and External Appeals Process and Consumer Assistance.
 - The Departments will issue model notices. These notices, when available, will be posted at <http://www.dol.gov/ebsa/> and <http://www.hhs.gov/ociio/>.
6. If a plan or insurance carrier fails to strictly adhere to the requirements of the internal claims and appeals process with respect to a claim, a claimant will be deemed to have exhausted the internal claims and appeals process and may, upon such a failure, initiate an external review and pursue any available remedies under applicable law.

Further, the regulations require a group health plan and insurance carrier to provide continued coverage pending the outcome of an internal appeal. Individuals in urgent care situations and individuals receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process, under either the State or Federal external review process (whichever is applicable).

in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage;
- A determination that benefit is not a covered benefit;
- The imposition of a pre-existing condition exclusion, source of injury exclusion, network exclusion or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental or investigational or not medically necessary or appropriate.

EXTERNAL REVIEW

The regulations identify two mechanisms for an external review: a State External Review and a Federal External Review.

- State External Review applies to the insurance carrier of the group health plans and self-insured plans that are not subject to ERISA (e.g. church plans, non-federal government plans). The State external review will apply provided certain minimum requirements are met (see discussion below). If the State's review process does not meet the minimum requirements, then the Federal external review process will apply.
- Federal External Review will apply to self-insured group health plans that are not subject to State insurance regulations (i.e. most employer-sponsored self-insured plans). Also, in the case where a State does not satisfy the minimum requirements, a carrier or plan will be subject to the Federal external review process.

To the extent that benefits under a group health plan are provided through health insurance coverage (i.e. an insured group health plan) and the carrier is subject to the State review process, the plan is not required to comply with the State or Federal external review process; the compliance obligation for an external review rests with the health insurance carrier.

Minimum Standards for State External Review Processes

An applicable State external review process must meet all of the minimum consumer protections under the National Association of Insurance Commissioners Uniform Health Carrier External Review Model Act (NAIC Model Act). The Department of Health and Human Services will determine whether a State review process meets the prescribed requirements.

Briefly, the minimum requirements for an external review of an adverse benefit decision require the following:

- Provide for the external review based upon medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit;
- Require insurance carriers (or, if applicable, the plan) to provide effective written notice to claimants of their rights in connection with the external review;
- Provide alternative requirements for external review in certain cases where claimants have not exhausted internal procedures (e.g. where the carrier or plan waives the exhaustion requirements or the carrier or plan is deemed to have exhausted the internal claims procedures by not strictly adhering to the required appeals process);
- Carriers (or, if applicable, the plan) must pay the costs of an Independent Review Organization (IRO) to conduct the external review and individuals can only be charged a nominal filing fee (not to exceed \$25);
- No minimum claim value requirement;
- At least a four-month period to request an external review after receipt of an adverse benefit decision;
- IROs are assigned on a random basis or other method that assures the independence and impartiality of the assignment process, and in no event is selected by the issuer, plan or individual;
- States maintain a list of Qualified IROs that are appropriately credentialed;
- The State process must ensure that the approved Qualified IRO does not have a conflict of interest that will influence its independence and impartiality (i.e. is not owned by an insurance carrier or the sponsor of a group health plan);
- Properly notify the claimant of the ability to submit in writing additional information to the IRO and allow the IRO to consider the additional information when conducting an external review. Such information must also be provided to the insurance carrier;

- All final reviews are binding on both parties;
- A 45-day deadline for the issuance of a final decision by the IRO;
- A 72-hour deadline for the issuance of a final decision in certain circumstances (48 hours if notice is not in writing);
- Written description of the review process in the group health plan SPD and insurance booklet;
- Requirement that IROs keep written records of all reviews and decisions and make them available upon request; and
- That experimental services and treatments be considered.

There is some transition relief available for existing processes where there is a State external review mechanism in place. The State external process will be considered binding on an insurance carrier (or, if applicable, a plan) for plan years beginning before July 1, 2011. For plan years that begin on or after July 1, 2011, the State process will be binding as long as it meets the minimum requirements. If not, then the Federal process will apply.

Federal External Review Requirements

A plan or insurance carrier not subject to the State external review process will need to provide an effective Federal external review process. The Federal external review process applies to any adverse benefit determination except determinations as they relate to eligibility under the terms of the group health plan. This is the process that will apply to most employer-sponsored self-insured plans.

The Federal review process will be similar to the process laid out in the NAIC Model Act and includes additional standards to be set out in future regulations (in other words, more guidance is needed).

These standards are expected to include the following:

- A process for claimants to initiate an external review, procedures for a preliminary review, minimum qualifications for an IRO, the process for approving an IRO to conduct an external review, standards for IRO decision making and rules for providing notice of a final external review decision;
- An expedited external review process;
- For experimental and investigational treatments, the development of standards that will provide additional consumer protections to ensure adequate clinical and scientific experience and protocols are taken into account as part of the external review process;
- Provide that an external review decision is binding on the plan or insurance carrier, as well as the claimant, except to the extent other remedies are available under State or Federal law;
- May establish external review reporting requirements for IROs;
- Establish additional notice requirements for plans and insurance carriers regarding disclosures to participants describing the Federal external review procedures; and
- Require a plan or insurance carrier to provide information relevant to the processing of the external review.

NOTICE

Notices provided in connection with the claims procedures and appeals process must be made available in a “culturally and linguistically appropriate” manner, primarily providing notice in a non-English language:

- For plans covering less than 100 participants on the first day of the plan year, if at least 25% of participants are literate in the same non-English language; or

- For plans covering more than 100 participants on the first day of the plan year, if the lesser of 500 or 10% of participants are literate in the same non-English language.

In addition to providing the non-English language notices, the plan or issuer must:

- Include a statement in the English version notice that is prominently displayed, written in the applicable non-English language and offers the non-English language notice to participants;
- Provide all subsequent notices in the applicable non-English language to any claimant who has requested a non-English notice; and
- If customer assistance is available to participants (for example, a telephone hotline), make that assistance available in any required non-English language.

For a copy of the regulations, visit: <http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=24056>.

For a Fact Sheet, visit: <http://www.dol.gov/ebsa/newsroom/fsaffordablecareact.html>.



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APPENDIX
CLAIMS PROCEDURES FOR GROUP HEALTH PLANS

(The following summarizes current ERISA claims procedures as defined under 29 CFR § 2560.503-1. It does not reflect additional requirements imposed by the Patient Protection and Affordable Care Act and applicable regulations.)

Rights of any claimant described in these procedures also extend to any authorized representative of the claimant.

BENEFIT DETERMINATION

The Plan Administrator will notify a claimant of the Plan's benefit determination as follows:

Urgent care claims.

In the case of a claim involving urgent care, the Plan Administrator will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan unless the claimant fails to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded the claimant to provide the specified additional information.

Concurrent care decisions.

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims.

In the case of a pre-service claim, the Plan Administrator will notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

In the case of a failure by a claimant to follow the plan's procedures for filing a pre-service claim, the claimant will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification will be provided to the claimant as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant.

Post-service claims.

In the case of a post-service claim, the Plan Administrator will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Written notification will set forth, in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination is based.
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- Concerning a claim involving urgent care, a description of the expedited review process applicable to such claims. In the case of an adverse benefit determination, the information described above may be provided to the claimant orally, provided that a written notification is furnished to the claimant not later than 3 days after the oral notification.

APPEAL OF ADVERSE BENEFIT DETERMINATIONS

Claimants have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

A claimant will be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

Claimants have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination.

A review does not afford deference to the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

This health care professional will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

In the case of a claim involving urgent care, there will be an expedited review process pursuant to which:

- a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant, and
- all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

The Plan Administrator will notify a claimant of the Plan's benefit determination on review as follows.

Urgent care claims.

In the case of a claim involving urgent care, the Plan Administrator will notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

Pre-service claims.

In the case of a pre-service claim, the Plan Administrator will notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. [OR in the case of a group health plan that provides for two appeals of an adverse determination, such notification will be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the Plan of the claimant's request for review of the adverse determination.]

Post-service claims.

The Plan Administrator will notify the claimant of the Plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. [OR in the case of a group health plan that provides for two appeals of an adverse determination, such notification will be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.]

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

The Plan Administrator will provide a claimant with written notification of the Plan's benefit determination on review.

In the case of an adverse benefit determination, the notification will set forth, in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the benefit determination is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.
- A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures.
- A statement of the claimant's right to bring an action under section 502(a) of ERISA.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." [Pending further review, the DOL will not enforce compliance with the requirement to include the language contained in this bullet point.]

DEFINITIONS

Claim involving urgent care means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- (A) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or,
- (B) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Except as provided in the sentence immediately following this one, whether a claim is a “claim involving urgent care” within the meaning of paragraph (A) is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a “claim involving urgent care” will be treated as a “claim involving urgent care.”

Pre-service claim means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Post-service claim means any claim for a benefit under a group health plan that is not a pre-service claim.

Adverse benefit determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Health care professional means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.